

11401

# CERTIFICATE OF DEATH

11405

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>115 Humbird Street</u>				STREET ADDRESS (If rural give location) <u>115 Humbird Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CARRIE</u> <u>JANE</u> <u>ATHEY</u>				<b>4. DATE OF DEATH</b> (Month) <u>Dece.</u> (Day) <u>27</u> (Year) <u>19 55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Apr. 1, 1883</u>	<b>9. AGE last birthday</b> <u>72</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Allegany Co. Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John Hinkle</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Wagner</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>115 Humbird Street</u> <u>Geo. F. Athey, Cumberland, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.1 IMMEDIATE CAUSE</b> (A) <u>Acute Coronary Occlusion</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Seconds</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u>Arteriosclerotic Cardio Vascular Disease</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <u>Advanced Age</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE</b> (Home, farm, factory, or injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>County medical officer notified</u>			
<b>22. I hereby certify</b> that I attended the deceased from <u>August 19 54</u> to <u>Dec 19 55</u> , that I last saw the deceased alive on <u>Sept 19 55</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>J. O. Hummel</u>		<b>ADDRESS</b> (Street, city, town, state) <u>133 Va. Ave, Cumberland, Md</u>		<b>DATE SIGNED</b> <u>12/28/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE WHEREOF</b> <u>Dec. 31, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Bur. Park</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Cumberland, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Dec 31, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Walter R. Frank, M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Hafer</u>		<b>ADDRESS</b> <u>Cumberland, Maryland</u>	



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11406

## 11452 CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>22 Frostburg</u>		LENGTH OF STAY (in this place) <u>4 Mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Route 1, Frostburg,</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 Frost Avenue</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Clara Brown Atkinson</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 2nd, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 11th, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James P. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Christine Hott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Leslie Brode, Frostburg, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Accident (hemorrhage) multiple</u>						<u>13 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis - advanced</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>						<u>Years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>6</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>48</u> , to <u>Dec. 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 1</u> , 19 <u>55</u> , and that death occurred at <u>5:10</u> M. from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u>		ADDRESS (Street, city, town, state) <u>M.D. Frostburg, Maryland</u>		DATE SIGNED <u>Dec. 2, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-4-1955</u>		NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>12-4-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11407

11402

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

Item 1, Film G190 12-21-55 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>		TOWN <u>Mt. Savage</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>		TOWN <u>Mt. Savage</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>New Row</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Frances Clara Barrett</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 14th, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>August 5th, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glenn Sav. Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James E. Barrett</u>				14. MOTHER'S MAIDEN NAME <u>Mary V. Lucky</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-01-8665</u>		17. INFORMANT & ADDRESS <u>Mrs. Arthur Walsh, Mt. Savage, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
410X IMMEDIATE CAUSE (A) <u>RHEUMATIC HEART DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>MANY YEARS</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>MITRAL REGURGITATION, ADVANCED</u>						<u>MANY YEARS</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>✓</u>		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>✓</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>11/25</u> , 19 <u>55</u> , to <u>12/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>55</u> , and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Joseph R. Durst, M.D.</u>				ADDRESS (Street, city, town, state) <u>48 Broadway - Frostburg Md. 12/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Joseph R. Durst</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

# 1950 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Date No.

1. Usual Residence of Deceased

2. Name of Deceased

3. Sex

4. Age

5. Date of Death

6. Place of Death

7. Date of Death

8. Cause of Death

9. Place of Death

10. Name of Physician

11. Name of Physician

12. Name of Physician

13. Name of Physician

14. Name of Physician

15. Name of Physician

16. Name of Physician

17. Name of Physician

18. Name of Physician

19. Name of Physician

20. Name of Physician

21. Name of Physician

22. Name of Physician

23. Name of Physician

24. Name of Physician

25. Name of Physician

26. Name of Physician

BUREAU V. S.

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27. Name of Physician

28. Name of Physician

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11408

11453

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg,</u>		<u>Lifetime</u>		TOWN <u>Frostburg,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 Chestnut Street</u>				STREET ADDRESS (If rural give location) <u>6 Chestnut Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Eliza</u> (Middle) <u>Ellen</u> (Last) <u>Beaver</u>				<u>Dec. 1st,</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 22nd, 1864</u>	<u>91</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housework</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Martin Knepp</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Gowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>None</u>		<u>Mrs. David Kiddy, Frostburg, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio-sclerotic Cardio-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>vascular disease</u>				<u>10 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-1</u> , 19 <u>55</u> , to <u>12-1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-1</u> , 19 <u>55</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. C. Adich</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>12-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-4-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mr. Nancy N. Paz</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	
DATE <u>12-4-55</u>							



11403

## CERTIFICATE OF DEATH

DR. HIMMELWRIGHT

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY MARYLAND				STATE MARYLAND COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
02 TOWN CUMBERLAND		35		CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL				1012 ELLA AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ARTHUR (Middle) C. (Last) BROWN				(Month) DECEMBER (Day) 1, (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	JANUARY 21, 1904	51 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Attendant at Bykesville State Hospital			NONE		MARYLAND		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM BROWN				BETTY ALKIRE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		220-10-2461		MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						35 days	
053.1 IMMEDIATE CAUSE (A) Empyema, Pericarditis, Peritonitis,							
ANTECEDENT CAUSE(S) (B) Abscess left Kidney							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Fulminating Staphylococcus Septicemia.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus - Uncontrolled.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 19 55, to Nov. 19 55, that I last saw the deceased alive on Nov 30, 19 55, and that death occurred at 5:15 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state) DATE SIGNED			
St. Quentin Himmelwright M.D.				133 Virginia Ave, Cumberland, Md. 11/1			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Dec. 3, 1955		Alkire Family Cemetery		near Fort Ashby, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Dec. 2, 1955		Walter R. Brantz M.D.		James F. Scarpelli, Cumberland, Maryland			

**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



CERTIFICATE OF DEATH

Exp. Date No.

1. Name of Deceased: HENRY ARTHUR BROWN JR.

2. Place of Death: HOME

3. Sex: MALE

4. Race: WHITE

5. Date of Birth: 1915

6. Date of Death: 1955

7. Cause of Death: HEART DISEASE

8. Place of Birth: NEW YORK

9. Date of Admission: 1955

10. Date of Discharge: 1955

11. Date of Death: 1955

12. Date of Death: 1955

13. Date of Death: 1955

14. Date of Death: 1955

15. Date of Death: 1955

16. Date of Death: 1955

17. Date of Death: 1955

18. Date of Death: 1955

BUREAU V. 3

EC 5 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11404				11410			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				No. 4			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
TOWN <u>Cumberland</u>		<u>119 days</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural, give location) <u>624 Washington St.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) <u>Mary</u>		<u>Elizabeth</u> <u>Cain</u>		<u>Dec.</u> <u>13</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>widow</u>	<u>June 9-1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>Own home</u>		<u>Brooklyn, N.Y.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John C. Gillespie</u>				<u>Mary Cameron</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>Sacred Heart Hospital</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)..... <u>Myocardial failure</u>						<u>gradual</u>	
DUE TO						<u>several</u>	
Antecedent cause(s) (b)..... <u>Arteriosclerosis</u>						<u>years.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of the right humerus.</u>						<u>since Aug. 16/55</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
<u>0</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>home</u>		21c. (City or town) (County) (State)			
<u>Cumberland</u> <u>Allegany</u> <u>01</u> <u>Md.</u>							
21d. TIME (Month) (Day) (Year) <u>12-30</u> OF INJURY <u>Aug. 16-1955 A.M.</u>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>Sitting on side of bed &amp; fell to the floor.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		H.V. Deming M.D. <u>H.V. Deming M.D.</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec. 13-1955</u>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 16, 1955</u>		<u>St. Peter and Paul Cem.</u>		<u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec. 14, 1955</u>		<u>Walter R. Trantz, M.D.</u>		<u>James F. Scarfelli</u>		<u>"</u>	

BUREAU V. S.

DEC 16 1935

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11411

# 11405 CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>PA.</b> COUNTY <b>BEDFORD</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>75X-3</b>		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02</b>		LENGTH OF STAY (in this place) <b>98 1/4 HOURS</b>		TOWN <b>CUMBERLAND</b>		TOWN <b>BEDFORD</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60 MEMORIAL HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>340 W. PITT ST.</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>BABY GIRL CLAYCOMB</b>				<b>12 12 19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Mins	
<b>FEMALE</b>	<b>WHITE</b>		<b>12-11-55</b>			<b>9 45</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
		<b>None</b>		<b>Cumberland, Maryland.</b>		<b>USA</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>CLAYCOMB, LONDON D.</b>				<b>SILL, JEAN L.</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No</b>				<b>MEMORIAL HOSPITAL</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>776X IMMEDIATE CAUSE (A)</b>				<b>Prematurity</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 12/11/55 to 12/12/55, that I last saw the deceased alive on 12/11/55, and that death occurred at 1:10AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>			
<b>W. R. Hedges</b>		<b>Cumberland, Md</b>		<b>12/13/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Cremation</b>		<b>Dec. 14, 1955</b>		<b>Memorial Hospital</b>		<b>Cumberland, Maryland.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<b>Mr. 14, 1955</b>		<b>Winter R. Frantz, M.D.</b>		<b>Memorial Hospital, Cumberland, Maryland.</b>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

20V5274301

# MASS CERTIFICATE OF DEATH

FILE NO.

1. REGISTRATION DISTRICT OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF UNION

23. SIGNATURE OF PARTY

24. SIGNATURE OF GROUP

25. SIGNATURE OF ORGANIZATION

26. SIGNATURE OF INSTITUTION

27. SIGNATURE OF AGENCY

28. SIGNATURE OF OFFICE

29. SIGNATURE OF DIVISION

30. SIGNATURE OF DEPARTMENT

31. SIGNATURE OF SECRETARY

32. SIGNATURE OF ASSISTANT

33. SIGNATURE OF CLERK

34. SIGNATURE OF RECEPTIONIST

35. SIGNATURE OF MAIL ROOM

MASSACHUSETTS

DEPARTMENT OF HEALTH

BATIMORE 18

MASSACHUSETTS

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DEPARTMENT OF HEALTH

BATIMORE 18

MASSACHUSETTS

1. REGISTRATION DISTRICT OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF UNION

23. SIGNATURE OF PARTY

24. SIGNATURE OF GROUP

25. SIGNATURE OF ORGANIZATION

26. SIGNATURE OF INSTITUTION

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33. SIGNATURE OF CLERK

34. SIGNATURE OF RECEPTIONIST

35. SIGNATURE OF MAIL ROOM

MASSACHUSETTS DEPARTMENT OF HEALTH-BATIMORE 18

RECEIVED  
DEC 16 1955  
BUREAU V. S.



When certificate is filed with the registrar within 72 hours after death, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11412

11406 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
02 TOWN <u>Cumberland.</u>		70 yrs		02 TOWN <u>Cumberland, Md.</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>122 So. Liberty St.</u>				122 So. Liberty St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Mary P. Conley</u>				<u>I2 3 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>Dec. 5, 1877</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Ownhome</u>		<u>Pittsburg, Pa.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John T. Parker</u>				<u>Bridgett E. Deavy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>John T. Conley 122 So. Liberty St.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A) <u>Carcinoma, stomach</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 12/1</u> , 19 <u>55</u> , to <u>12/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> , and that death occurred at <u>10:47</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Leo J. Conley Jr.</u>				ADDRESS (Street, city, town, state) <u>456 N. Center St. Cumberland</u>			
DATE <u>12/6/55</u>				DATE SIGNED <u>12/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>12-7-55</u>		<u>St Peter and Paul Cem</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 5, 1955</u>		<u>Walter R. Franz, M.D.</u>		<u>James F. Scarpelli</u>		<u>Cumberland, Md</u>	

# CERTIFICATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

DEC 6 1955

RECEIVED

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11407 CERTIFICATE OF DEATH

11413

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Md.</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>14</u> hrs.		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>652 Fayette St.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Rex LeClare Cope</u>				<u>Dec. 26 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>11/23/1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Inspector</u>		<u>St. Roads Comm.</u>		<u>Penna. DuBois</u>		<u>U. S.</u>	
13. FATHER'S NAME <u>Elmer Cope (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Julia (Thompson) (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>214-07-3083</u>		<u>652 Fayette St.,</u> <u>Wife--Chart Mrs. Genevieve Cope</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
153X IMMEDIATE CAUSE (A) <u>Chronic of colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 25, 1955</u> , to <u>Dec 26, 1955</u> , that I last saw the deceased alive on <u>Dec 26, 1955</u> , and that death occurred at <u>10:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>R. M. Schneider M.D.</u>				ADDRESS (Street, city, town, state) <u>41 South Cumberland St. Md.</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/28/55</u>		<u>S. S. Peter &amp; Pauls Cem.</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 28, 1955</u>		<u>Walter R. Vandy M.D.</u>		<u>Charles L. George</u>		<u>Cumberland, Md.</u>	

# CERTIFICATE OF DEATH

1. DECEASED PERSON'S NAME OR RECORD NO.

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. MARITAL STATUS

11. COLOR

12. EDUCATION

13. RELIGION

14. US BIRTH

15. US CITIZENSHIP

16. US RESIDENCE

17. US DEATH

18. US DEATH

19. US DEATH

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BUREAU V. S.

DEC 29 1955

RECEIVED

20010012321

THIS CERTIFICATE IS TO BE FILLED OUT BY THE REGISTRAR OF DEATHS, WHO SHALL SIGN IT AND RETURN IT TO THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE SENT TO THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

11414

11408

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 TOWN CUMBERLAND</b>		LENGTH OF STAY (in this place) <b>22 HRS.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 TOWN CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>703 ELM STREET</b>			
<b>3. NAME OF DECEASED</b> (First) <b>JOHN</b> (Middle) <b>F</b> (Last) <b>COUTER</b>				<b>4. DATE OF DEATH</b> (Month) <b>DECEMBER</b> (Day) <b>12</b> (Year) <b>1955</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>SEPTEMBER 17 1879</b>	<b>9. AGE last birthday</b> <b>76 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Mill-Wright</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>B. &amp; O. RR.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>GEORGE COUTER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>MARGARET REID</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>705-05-4598</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL AND WARWICK AVENUES</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>443X IMMEDIATE CAUSE (A)</b> <b>CONGESTIVE HEART FAILURE - ACUTE</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>10 min</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>HYPERTENSIVE CARDIOVASCULAR DISEASE,</b>				<b>Years.</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <b>CHRONIC MYOCARDITIS</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from August, 1954, to Dec, 1955, that I last saw the deceased alive on Dec 12, 1955, and that death occurred at 2:20 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>St. Quentin Amundson, M.D.</i>				<b>DATE SIGNED</b> <b>12/13/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Dec 15 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Cumberland, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Dec 14, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Walter R. Prantz, M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Byron Kight,</b>		<b>ADDRESS</b> <b>Cumberland, Md.</b>	



RECEIVED  
EC 16 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11459  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11415  
Reg. Dist. 2

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Minnesota</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town): <u>X TOWN Rural) Cumberland, Md.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Minneapolis</u> <u>box-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Town Hill Route 40</u>				STREET ADDRESS (If rural, give location) <u>3754 Edmund Blvd.</u> <u>✓</u>			
3. NAME OF DECEASED: (First) <u>Robert</u>		(Middle) <u>Miller</u>		(Last) <u>Dahl</u>		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>5</u> (Year) <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Aug. 26-1933</u>	9. AGE last birthday: <u>22</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Mill worker</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Steel</u>		11. BIRTHPLACE (State or foreign country): <u>St. Cloud, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Leslie H. Dahl</u>				14. MOTHER'S MAIDEN NAME: <u>Irene Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u>		(If Yes, give war or dates of service) <u>1954 &amp; 55</u>		16. SOCIAL SECURITY No.: <u>471-30-2350</u>		17. INFORMANT & ADDRESS: <u>Leslie H. Dahl (father) Minneapolis, Minn.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				sudden	
Immediate cause (a) <u>Intracranial hemorrhage</u>		DUE TO			
Antecedent cause(s) (b) <u>fractured skull also had fractured right femur</u>		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>(auto accident) and lacerations of scalp.</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>Dec. 5-1955</u>		19b. MAJOR FINDING OF OPERATION: <u>(Town Hill)</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY, <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>✓</u>	21b. PLACE (Home, farm, factory, street, office bldg, etc.,) OF INJURY: <u>Route 40</u>	21c. (City or town) <u>Cumberland</u> (County) <u>Allegany</u> (State) <u>Md.</u>			
21d. TIME (Month) (Day) (Year) <u>Dec. 5-1955</u> <u>5 A.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Lost control of auto, hit guard rails, thrown out.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec. 5-1955</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Acacia Memorial Park</u>	
LOCATION (City, town, or county) (State) <u>Minneapolis Minnesota</u>		24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumb. Md.</u>			
DATE REC'D BY LOCAL REG. <u>Dec. 5, 1955</u>		REGISTERAR'S SIGNATURE <u>Anna R. Bender</u>		ADDRESS <u>Stein</u>	

BUREAU V. S.

DEC 12 1955

RECEIVED

Item 21 Film G191 1-13-56

11409

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>Lifetime</u>		TOWN <u>Cumberland, Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital (D.O.A.)</u>				STREET ADDRESS (If rural give location) <u>R.F.D.#1 LaVale, Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Deborah</u> (Middle) <u>Sue</u> (Last) <u>Dean</u>				(Month) <u>12</u> (Day) <u>29</u> (Year) <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Single</u>	<u>12-7-54</u>	<u>I</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Cumberland, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Milford Dean</u>				<u>Philos McCarty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Milford Dean R.F.D.#1 LaVale Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
921.0 IMMEDIATE CAUSE (A) <u>Asphyxiation due to aspiration of gastric contents</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>of gastric contents</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Enteritis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input checked="" type="checkbox"/>		<u>home</u>		<u>Allegany</u>		<u>Allegany</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 27</u> , 19 <u>55</u> , to <u>Dec 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>55</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>James F. Scarpelli</u>		<u>133 Va Ave Cumberland, Md</u>		<u>12/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county)	
<u>Burial</u>		<u>12-31-55</u>		<u>Hillcrest Burial Park</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Dec. 31, 1955</u>		<u>Walter L. Frantz, M.D.</u>		<u>James F. Scarpelli</u>			
				ADDRESS <u>Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

ROULETTE

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RECEIVED



1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11410

CERTIFICATE OF DEATH

11417

Reg. Dist. No. 4

INSTRUCTIONS

1. The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>8 days</u>		TOWN <u>Westernport</u>		<u>43</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>305 Hammond Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lawrence</u> (Middle) <u>Densmore</u> (Last)				(Month) <u>Dec.</u> (Day) <u>13</u> (Year) <u>19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Sept. 25, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B&amp;O Blacksmith helper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Newburg, West Virginia.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Lawrence Densmore</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Stone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>4 No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Genevieve Densmore (wife)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <u>Pulmonary Hypostasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 5</u> , 19 <u>55</u> , to <u>Dec. 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 12</u> , 19 <u>55</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James E. McLean</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Greene St.</u> DATE SIGNED <u>12-13-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Maryland.</u>	
24. REC'D BY REGISTRAR <u>Dec. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Lantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth S. Boal</u> ADDRESS <u>Westernport, Maryland.</u>			

# CERTIFICATE OF DEATH

Form 10-1-1917

1. PLACE OF DEATH

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH

2. CAUSE OF DEATH

IMMEDIATE CAUSE  
 REMOTE CAUSE  
 MANNER OF DEATH

3. MEDICAL CERTIFICATION

4. SIGNATURE OF DECEASED

5. SIGNATURE OF WITNESSES

6. SIGNATURE OF REGISTRAR

7. SIGNATURE OF CLERK

8. SIGNATURE OF JUDGE

9. SIGNATURE OF SHERIFF

10. SIGNATURE OF CORONER

11. SIGNATURE OF JURY

BUREAU V. S.

DEC 16 1915

RECEIVED

ENCLOSURE

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11418

11454 **CERTIFICATE OF DEATH**Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>3 weeks</u>		TOWN <u>Triple Lakes, Cresaptown</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miner's Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Annie</u> (Middle) <u>Susan</u> (Last) <u>Dixon</u>				Dec. <u>4th</u> , 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 4th, 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housework</u>		<u>West Virginia</u>		<u>USA</u>	
13. FATHER'S NAME <u>Columbus Paugh</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Kitzmiller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>None</u>		<u>None</u>		<u>Mrs. Naomi Dixon, Rt. 2, Frostburg</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
180X IMMEDIATE CAUSE (A) <u>Carcinoma Kidneys</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastatic Ca. throughout</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Her entire body.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/1</u> , 19 <u>55</u> , to <u>12/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>55</u> , and that death occurred at <u>9:25</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u>		DATE SIGNED <u>12/6/55</u>		ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-8-1955</u>		NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. Nancy H. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

BUREAU V. S.

RECEIVED

100-443886-100

BUREAU V. S.

DEC 12 1962

RECEIVED

11411

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <b>ALLEGANY</b> CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>CUMBERLAND</b> TOWN <b>CUMBERLAND</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>RT. RAWLINGS</b> TOWN <b>RAWLINGS</b> STREET ADDRESS (If rural give location) <b>X</b>			
3. NAME OF DECEASED (Type or Print) (First) <b>NIMROD</b> (Middle) <b>DUCKWORTH</b> (Last) <b>DUCKWORTH</b>				4. DATE OF DEATH DEC. 26 1955			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>MARCH 6, 1878</b>	9. AGE last birthday <b>77</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Westernport, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THORNTON DUCKWORTH</b>				14. MOTHER'S MAIDEN NAME <b>OLIVE MILLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>LINK NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>MEMORIAL HOSPITAL</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 153X IMMEDIATE CAUSE (A) <b>Carcinoma of degotic flexure of Colon 6 mos.</b> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Metastatic carcinoma to bones</b>							
19a. DATE OF OPERATION <b>12-5-55</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Colon metastasis</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12-5-55</b> to <b>12-26-55</b> , that I last saw the deceased alive on <b>12-25-55</b> , and that death occurred at <b>12:05A.M.</b> from the causes and on the date stated above. SIGNATURE <b>X. B. [Signature]</b> ADDRESS (Street, city, town, state) <b>M.D. 122 S. Centre St. Cumberland Md</b> DATE SIGNED <b>12-27-55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec. 28, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		LOCATION (City, town, or county) (State) <b>Westernport, Maryland.</b>	
24. REC'D BY REGISTRAR <b>Dec. 27, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Frank, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth S. Boal, Westernport, Maryland.</b>			

## INSTRUCTIONS

1. WITHIN CORPORATE LIMITS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535  
JAN 10 1966

# CERTIFICATE OF DEATH

1. NAME OF DECEASED THOMAS DUCKWORTH		2. SEX MALE		3. RACE WHITE	
4. DATE OF DEATH JAN 10 1966		5. TIME OF DEATH 11:00 AM		6. PLACE OF DEATH HOSPITAL	
7. AGE 65		8. BIRTH DATE JAN 10 1901		9. BIRTH PLACE OLIVE HILL, MISSISSIPPI	
10. MARITAL STATUS MARRIED		11. OCCUPATION FARMER		12. CAUSE OF DEATH HEART DISEASE	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DISTRICT ATTORNEY		21. SIGNATURE OF COUNTY CLERK	
22. SIGNATURE OF TOWNSHIP CLERK		23. SIGNATURE OF VOTING CLERK		24. SIGNATURE OF POLL CLERK	
25. SIGNATURE OF JURY CLERK		26. SIGNATURE OF COURT CLERK		27. SIGNATURE OF CLERK OF SUPERIOR COURT	
28. SIGNATURE OF CLERK OF DISTRICT COURT		29. SIGNATURE OF CLERK OF COUNTY COURT		30. SIGNATURE OF CLERK OF JUDICIAL DISTRICT COURT	
31. SIGNATURE OF CLERK OF FEDERAL DISTRICT COURT		32. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		33. SIGNATURE OF CLERK OF U.S. SUPREME COURT	
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100. SIGNATURE OF CLERK OF U.S. SUPREME COURT		101. SIGNATURE OF CLERK OF U.S. SUPREME COURT		102. SIGNATURE OF CLERK OF U.S. SUPREME COURT	

BUREAU V. S.

DEC 28 1965

RECEIVED

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11455

## CERTIFICATE OF DEATH

11420

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
43 TOWN <u>Westernport</u>		51 years		TOWN <u>Westernport</u>		43	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 101 Howard St				101 Howard St			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
George Ellis				Dec 19 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widower	27 Dec 1881	73	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Merchant ret.		Grocery Store		Syria		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jual Ellis				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		None		101 Howard St Poland G. Ellis, Westernport, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				Cerebral Hemorrhage			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B)				Arterio-sclerosis and Hypertension			
(C)				Prostatic Hypertrophy			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				1 Year			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15 Minutes 2 Years	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr 2, 1955, to Dec 19, 1955, that I last saw the deceased alive on Dec 14, 1955, and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Paul D. Wilson				Prodent, W. Va.		Dec. 20, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12-21-55		St. Peters Cemetery		Westernport, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 12 21 55		Mrs Jean C Kelly		E. J. Boal		Westernport, Md.	

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or type)

2. Place of death

3. Date of death

4. Time of death

5. Age of deceased

6. Sex of deceased

7. Race

8. Marital status

9. Cause of death

10. Place of burial

11. Date of burial

12. Name of funeral home

13. Signature of physician

14. Signature of registrar

15. Signature of informant

16. Signature of witness

17. Signature of undertaker

18. Signature of clergyman

19. Signature of coroner

20. Signature of jury

21. Signature of jury

22. Signature of jury

23. Signature of jury

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74. Signature of jury

BUREAU V. S.

DEC 23 1955

RECEIVED

RECEIVED

11460

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1 Outside of City limits

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 (10M)

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Near TOWN Cumberland, rural</u>		LENGTH OF STAY (in this place) <u>71 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Near Cumberland, rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. #3, Bedford Road</u>				STREET ADDRESS (if rural give location) <u>Rt. #3, Union Grove Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Nina Fey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 9 19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 9, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hairdresser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. Fey</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Wilkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-22-3676</u>		17. INFORMANT & ADDRESS <u>Ruthella Fey Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute myocardial failure</u>						<u>Immediate</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Coronary Insufficiency</u>						<u>Immediate</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary Sclerosis + Old Coronary</u>						<u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive and arterio-sclerotic Heart Disease</u>						<u>10 years</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. et work) (Not while et work)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1947</u> , to <u>9 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 22 55</u> , and that death occurred at <u>10:42</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Paul C. Weisman</u>				ADDRESS (Street, city, town, state) <u>59 Greenest Cumberland Md</u>		DATE SIGNED <u>12/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 12, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		ADDRESS <u>Cumberland, Md.</u>	

BUREAU V. S.

DEC 14 1965

RECEIVED



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11422

11412

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Md.</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
OR TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>5 days</u>		OR TOWN <u>Frostburg</u>		STREET ADDRESS (If rural give location) <u>R.D. #1, Vale Summit</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS <u>R.D. #1, Vale Summit</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ANDREW</u> (First) <u>HENRY</u> (Middle) <u>FINN</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>12</u> (Day) <u>28</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>12 - 10 - 1874</u>	<b>9. AGE last birthday</b> <u>81</u> yrs.	<b>IF UNDER 1 YEAR</b> (Month) (Day) (Year)		<b>IF UNDER 24 HRS.</b> (Hours) (Min.)
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Store Room Clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; O R.R.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Vale Summit, Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>James Finn</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Jeanette Hawthorne</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>183 Mechanic St., Joseph Finn Frostburg, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>422.2 IMMEDIATE CAUSE</b> (A) <u>Myocardial Insufficiency</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 year</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Arterio Sclerosis</u>				<u>?</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>Dec 28, 1955</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Dec 24, 1955</u>, to <u>Dec 28, 1955</u>, that I last saw the deceased alive on <u>Dec 28, 1955</u>, and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>W. M. Lane</u>				<b>DATE SIGNED</b> <u>Dec 30, 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>24. REC'D BY REGISTRAR</b> <u>Mr. Nancy N. Ritz</u>			
<b>DATE THEREOF</b> <u>12-31-55</u>				<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Michaels Catholic</u>			
<b>LOCATION (City, town, or county) (State)</b> <u>Frostburg Md.</u>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B.H. Montross</u>			
<b>DATE</b> <u>12-31-55</u>				<b>ADDRESS</b> <u>23 E. Main Frostburg, Md.</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 6

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Luke</u>	LENGTH OF STAY (in this place) <u>8 hrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Westernport</u> <u>43</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>W.Va. Pulp &amp; Paper Co. Plant.</u>		STREET ADDRESS (If rural, give location) <u>513 B. Md. Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Joseph P. Francis</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 7 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>April 27-1907</u> <u>48</u> yrs.
9. AGE last birthday: <u>48</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>W.Va. P &amp; P. Co.</u>	11. BIRTHPLACE (State or foreign country): <u>Westernport, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Joseph Francis</u>		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>		16. SOCIAL SECURITY No.: <u>217-05-0428</u>	
17. INFORMANT & ADDRESS: <u>Dr. Best &amp; Jacobson also</u>		<u>Memorial Hospital Records, Cumberland, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary occlusion</u>			<u>sudden</u>
Antecedent cause(s) (b) <u>Chronic myocarditis with</u>			<u>about 5</u>
Diseases or conditions, if any, giving rise to the above cause DUE TO (c) <u>Coronary sclerosis.</u>			<u>years.</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec. 7-1955</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>W. Harold Fredlock</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>12/10/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	LOCATION (City, town, or county) (State) <u>Westernport Alleg. Md</u>
DATE REC'D BY LOCAL REG. <u>12-9-55</u>	REGISTRAR'S SIGNATURE <u>Mr. J. C. Kelly</u>	23. FUNERAL DIRECTOR <u>W. Harold Fredlock</u> ADDRESS <u>Piedmont, W. Va.</u>	

age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1955

RECEIVED

11413

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>CUMBERLAND,</b>		<b>10 DAYS</b>		TOWN <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1015 BEDFORD ST.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>RALPH E GANTT</b>				<b>DEC. 13, 1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>MALE</b>	<b>WHITE</b>	<b>MARRIED</b>	<b>NOV. 9 1889</b>	<b>66 yrs.</b>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Setting Monuments</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Monument Dealer</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Frostburg MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>GANTT, CONRAD</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>PARKER, RACHEL</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-05-7599</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL AND WARWICK AVES.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>332x IMMEDIATE CAUSE (A)</b> <b>BRONCHOPNEUMONIA</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 days</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> <b>Hypostasis secondary to</b>						<b>10 days</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b> <b>Cerebral Thrombosis</b>						<b>10 days</b>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Arteriosclerosis, general</b>						<b>3 years</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY-street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7/6, 1954, to Dec 13, 1955, that I last saw the deceased alive on Dec 13, 1955, and that death occurred at 9:12 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Heck G. Weisman</i>				<b>ADDRESS (Street, city, town, state)</b> <i>59 Brewster Cumberland</i>		<b>DATE SIGNED</b> <i>12/14/55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Dec 16 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St Luke's Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Cumberland Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <i>Dec 15, 1955</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Walter R. Lantz, M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Byron Kight,</b>		<b>ADDRESS</b> <b>Cumberland, Md.</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



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BUREAU V. S.

DEC 19 1955

RECEIVED

1. With the corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11425

11414

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY (in this place) 35 MINUTES		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CORRIGANVILLE		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY		(Middle) ELIZABETH		(Last) GOLDEN		(Month) DECEMBER 8 (Day) 19 (Year) 55	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MARCH 12, 1887	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME WEST SMITH				14. MOTHER'S MAIDEN NAME RACHAEL WALLMAN Bowser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS William Golden, Corriganville, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Acute Coronary Occlusion						hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Cardiovascular Disease						years.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) Arteriosclerosis							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April, 1955, to Dec, 1955, that I last saw the deceased alive on Dec 8, 1955, and that death occurred at 2:20 P.M. from the causes and on the date stated above.							
SIGNATURE J. Christon Hemminger, M.D.				ADDRESS (Street, city, town, state) 1336a Ave. Cumberland, Md		DATE SIGNED 12/10/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 11, 1955		NAME OF CEMETERY OR CREMATORY Lyndman Cemetery Lyndman, Pa		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR Dec. 11, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Harvey A. Leigler, Lyndman, Pa		ADDRESS	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

DEC 14 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11426

11462

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Flintstone</u>				TOWN <u>Rural Flintstone</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. # 2</u>				STREET ADDRESS (If rural give location) <u>R.D. # 2</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Mary</u> (Middle) <u>Ellen</u> (Last) <u>Gordon</u>				(Month) <u>Dec.</u> (Day) <u>17</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-16-1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Bedford Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Martin L. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Emily Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Martin M. Gordon Rt. 1 Flintstone, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
391X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/16</u> , 19 <u>55</u> , to <u>12/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/16</u> , 19 <u>55</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. D. Hodges</u> M.D.				ADDRESS (Street, city, town, state) <u>Near Flintstone Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-19-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Green Meadow Cem.</u>		LOCATION (City, town, or county) (State) <u>Near Flintstone Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Thos. L. Bender</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

11158

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

2

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. TIME OF BIRTH

11. PLACE OF DEATH

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF BIRTH

15. DATE OF BIRTH

16. TIME OF BIRTH

17. PLACE OF DEATH

18. DATE OF DEATH

19. TIME OF DEATH

20. PLACE OF BIRTH

21. DATE OF BIRTH

22. TIME OF BIRTH

23. PLACE OF DEATH

24. DATE OF DEATH

25. TIME OF DEATH

26. PLACE OF BIRTH

27. DATE OF BIRTH

28. TIME OF BIRTH

29. PLACE OF DEATH

30. DATE OF DEATH

31. TIME OF DEATH

32. PLACE OF BIRTH

33. DATE OF BIRTH

34. TIME OF BIRTH

35. PLACE OF DEATH

36. DATE OF DEATH

37. TIME OF DEATH

38. PLACE OF BIRTH

39. DATE OF BIRTH

40. TIME OF BIRTH

BUREAU V. S.

DEC 23 1915

RECEIVED

This is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 23rd day of December, 1915.

RECEIVED

THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON THE 23RD DAY OF DECEMBER, 1915.



11415

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)

TOWN Cumberland

LENGTH OF STAY  
(In this place)

62 years

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

128 Polk St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL end give nearest town)

OR

TOWN

Cumberland

STREET  
ADDRESS

128 Polk St.

3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

JOHN

E.

HERING

4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

Dec. 27,

19

55

## 5. SEX

Male

6. COLOR OR  
RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Single

## 8. DATE OF BIRTH

Feb. 8, 1893

## 9. AGE last birthday

62 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Plumber

10b. KIND OF BUSINESS  
OR INDUSTRY

Plumbing &amp; Heating

## 11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME

Frederick Hering

## 14. MOTHER'S MAIDEN NAME

Clara L. Ogle

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

215-18-8521

## 17. INFORMANT &amp; ADDRESS

Helen V. Hering, Cumberland, Md.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

## IMMEDIATE CAUSE (A)

(A)

Coronary infarction

## ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST,

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH

1 Hour

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 27, 19 55, to Dec 27, 19 55, that I last saw the deceased alive on Dec 27, 19 55, and that death occurred at 12:00 PM, from the causes and on the date stated above. 12/27/55

## SIGNATURE

R. M. Dravaskis, Sr.

M.D.

## ADDRESS (Street, city, town, state)

Cumberland Maryland

## DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

Dec. 30, 1955

## NAME OF CEMETERY OR CREMATORY

St. Lukes Cemetery

## LOCATION (City, town, county)

Cumberland, Md.

(State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

Dec. 28, 1955 Walter R. Harty, M.D.

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

William H. Kight, Cumberland, Md.

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. RACE

15. SOCIAL CLASS

16. DATE OF DEATH

17. TIME OF DEATH

18. PLACE OF DEATH

19. CAUSE OF DEATH

20. DATE OF DEATH

21. TIME OF DEATH

22. PLACE OF DEATH

23. CAUSE OF DEATH

24. DATE OF DEATH

25. TIME OF DEATH

26. PLACE OF DEATH

27. CAUSE OF DEATH

28. DATE OF DEATH

29. TIME OF DEATH

30. PLACE OF DEATH

31. CAUSE OF DEATH

32. DATE OF DEATH

33. TIME OF DEATH

34. PLACE OF DEATH

35. CAUSE OF DEATH

36. DATE OF DEATH

37. TIME OF DEATH

38. PLACE OF DEATH

39. CAUSE OF DEATH

40. DATE OF DEATH

41. TIME OF DEATH

42. PLACE OF DEATH

43. CAUSE OF DEATH

44. DATE OF DEATH

45. TIME OF DEATH

46. PLACE OF DEATH

47. CAUSE OF DEATH

48. DATE OF DEATH

49. TIME OF DEATH

50. PLACE OF DEATH

51. CAUSE OF DEATH

52. DATE OF DEATH

53. TIME OF DEATH

54. PLACE OF DEATH

55. CAUSE OF DEATH

56. DATE OF DEATH

57. TIME OF DEATH

58. PLACE OF DEATH

BUREAU V. S.

DEC 29 1955

RECEIVED

RECEIVED  
DEC 29 1955  
BUREAU V. S.

11416

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>02 Cumberland,</u>		LENGTH OF STAY (in this place) <u>3 1/2 hours</u>		CITY OR TOWN <u>Cresaptown</u>		CITY OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Harshbarger</u>				12- 9 1955			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 7, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel McKenzie</u>				14. MOTHER'S MAIDEN NAME <u>Alice Winter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Thomas Barnes, Cumberland, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.0 IMMEDIATE CAUSE (A) <u>congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>atherosclerotic heart disease</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>12-9-55</u> , 19 <u>55</u> , to <u>12-9-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-9-55</u> , 19 <u>55</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L. Mines</u>		M.D. <u>576 Green St. Cumberland</u>		DATE SIGNED <u>12-10-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cresaptown, Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 12, 1955</u>		REGISTRAR'S SIGNATURE <u>Winter R. Bantz M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles, L. George,</u> ADDRESS <u>Cumberland, Md.</u>			

1428

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

# CERTIFICATE OF DEATH

11618

Reg. Dist. No.

A. Usual Residence (Home or Place)

Place of Birth

MARYLAND

Color

Married

BUREAU V. S.

DEC 14 1900

RECEIVED

SMITHSONIAN

THIS CERTIFICATE OF DEATH IS ISSUED BY THE MARYLAND STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IS VALID FOR ALL PURPOSES. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE OF DEATH IN THE PRESENCE OF TWO OTHER PERSONS, ONE OF WHOM SHALL BE A MEMBER OF THE FAMILY OF THE DECEASED, OR A NEAR RELATIVE, OR A PERSON WHOSE INTEREST IN THE DECEASED IS KNOWN TO THE REGISTRAR. THE REGISTRAR SHALL SIGN THIS CERTIFICATE OF DEATH IN THE PRESENCE OF TWO OTHER PERSONS, ONE OF WHOM SHALL BE A MEMBER OF THE FAMILY OF THE DECEASED, OR A NEAR RELATIVE, OR A PERSON WHOSE INTEREST IN THE DECEASED IS KNOWN TO THE REGISTRAR. THE REGISTRAR SHALL SIGN THIS CERTIFICATE OF DEATH IN THE PRESENCE OF TWO OTHER PERSONS, ONE OF WHOM SHALL BE A MEMBER OF THE FAMILY OF THE DECEASED, OR A NEAR RELATIVE, OR A PERSON WHOSE INTEREST IN THE DECEASED IS KNOWN TO THE REGISTRAR.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11429

11463

## CERTIFICATE OF DEATH

Dr. Wilson

Reg. Dist. No. 60

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Barton</u>		<u>69 years</u>		TOWN <u>Barton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>/</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>George Harrison Howell</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec 26 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 21, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mine</u>	11. BIRTHPLACE (State or foreign country) <u>Barton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jefferson Howell</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-10-7999</u>		17. INFORMANT'S ADDRESS <u>George H. Howell, Barton, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.2 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis and Myocardial Degeneration</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>not specified as Rheumatism</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Chronic Myocarditis and Asthma</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>5 Years</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>Apr. 10</u>, 19<u>50</u>, to <u>Dec. 26</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec. 26</u>, 19<u>55</u>, and that death occurred at <u>7:45 A</u>.M, from the causes and on the date stated above.</b>							
SIGNATURE <u>Paul B. Wilson</u>				ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u>		DATE SIGNED <u>Dec. 27, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 29 55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
24. REC'D BY REGISTRAR <u>12-29-55</u>		REGISTRAR'S SIGNATURE <u>Marjorie C Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Bond</u>		ADDRESS <u>Westernport, Md.</u>	



# CERTIFICATE OF DEATH

1. IN WHAT DEPARTMENT OF DEATH?

2. IN WHAT DEPARTMENT OF DEATH?

3. IN WHAT DEPARTMENT OF DEATH?

4. IN WHAT DEPARTMENT OF DEATH?

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20. IN WHAT DEPARTMENT OF DEATH?

21. IN WHAT DEPARTMENT OF DEATH?

22. IN WHAT DEPARTMENT OF DEATH?

23. IN WHAT DEPARTMENT OF DEATH?

BUREAU V. S.

JAN 2 1966

RECEIVED

SHOULD BECOME

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11430

11456 **CERTIFICATE OF DEATH**Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>3 days</u>		TOWN <u>Frostburg</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Miners Hospital</u>				<u>47½ First St.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>CHARLOTTE LOUISE HUSTON</u>				<u>Dec. 21, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>12-4-1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housework</u>		<u>own home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wm. Robison</u>				<u>Rebecca Kirby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>Fred Huston, Frostburg, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A)				<u>Cerebral accident ("stroke")</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Atherosclerosis (advanced)</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				INTERVAL BETWEEN ONSET AND DEATH			
				<u>4 days</u>			
				<u>years -</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1, 19 55</u> , to <u>Dec 21, 19 55</u> , that I last saw the deceased alive on <u>Dec 21, 19 55</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis, M.D.</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>12/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-23-55</u>		<u>F'bg. Memorial Park</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-23-55</u>		<u>Wm. Harvey H. Roe</u>		<u>J. R. Durst,</u>		<u>Frostburg, Md.</u>	



11417

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MD.</b> COUNTY <b>ALLEGANY</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>FLINTSTONE</b>		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <b>CUMBERLAND</b>		LENGTH OF STAY (In this place) <b>2 DAYS</b>		STREET ADDRESS (If rural give location) <b>ROUTE # 2</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <b>WILLIAM</b> (Middle) <b>F.</b> (Last) <b>JAMES</b>				<b>DEC. 26, 19 55</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>NOV. 21, 1877</b>	<b>9. AGE last birthday</b> <b>78</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>WEST VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>PERRY JAMES</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ESTA CUNNINGHAM</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>422.1 IMMEDIATE CAUSE (A)</b> <b>Uremia - Congestive Heart Failure</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 wks</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> <b>STATING UNDERLYING CAUSE LAST.</b> <b>DUE TO</b> <b>(C)</b> <b>Hypertensive Cardiac Disease</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>12-29-55</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <b>M.</b>		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>Aug 19 50</b> <b>to</b> <b>Dec 19 55</b> , <b>that I last saw the deceased alive on</b> <b>Dec 25, 19 55</b> , <b>and that death occurred at</b> <b>10:15 A.M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>James E. Scarpelli</i>				<b>ADDRESS</b> (Street, city, town, state) <b>133 Va Ave, Cumberland, Md.</b>		<b>DATE SIGNED</b> <b>12/26/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>12-29-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Burial Park</b>		<b>LOCATION (City, town, or county)</b> <b>Cumberland, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Dec. 28, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Walter R. Gantz, M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>James E. Scarpelli</i>		<b>ADDRESS</b> <b>Cumberland, Md.</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11432

11454

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt Savage Road</u>				TOWN <u>Mt Savage Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt 4 Hyndman Pa</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Edward</u> (First) <u>Jenkins</u> (Middle) <u></u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Dec</u> (Day) <u>24</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Jan 7, 1915</u>		<b>9. AGE last birthday</b> <u>40</u> yrs.		<b>IF UNDER 1 YEAR</b> (Months) <u></u> (Days) <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Odd Jobs</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mt Savage, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>John W. Jenkins</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Florence Yeager</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>710</u>		<b>16. SOCIAL SECURITY NO.</b> <u>217-10-5825</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Edw. Jenkins Rt 4 Hyndman Pa</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>201X IMMEDIATE CAUSE</b> (A) <u>Hodgkin's Disease</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 yr.</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO							
<b>STATING UNDERLYING CAUSE LAST.</b> DUE TO							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>8</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, or INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <u></u> <u></u> <u></u> <u></u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 1955</u> , <b>to</b> <u>12/24/55</u> , <b>that I last saw the deceased alive on</b> <u>12/24/55</u> , <b>and that death occurred at</b> <u>11:1</u> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>John C. Topper</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Hyndman Pa</u>		<b>DATE SIGNED</b> <u>12/25/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12/26/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt Savage Meth. Cem</u>		<b>LOCATION</b> (City, town, or county) <u>Mt Savage Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Dec 26, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Veronica M. Hermelt</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Hager</u>		<b>ADDRESS</b> <u>Cumberland Md</u>	

# DEATH CERTIFICATE

This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and it should be signed by the physician or other qualified person who attended the deceased during his or her last illness. It should be filed in the office of the Registrar of Vital Statistics, and a copy should be sent to the office of the State Health Department. It should also be sent to the office of the local health department, if there is one. It should be kept for a period of ten years.

## CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1. NAME OF DECEASED

2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH

6. DATE OF DEATH  
7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF OTHERS

16. SIGNATURE OF OTHERS

17. SIGNATURE OF OTHERS

18. SIGNATURE OF OTHERS

19. SIGNATURE OF OTHERS

20. SIGNATURE OF OTHERS

BUREAU V. 3

JAN 5 1956

RECEIVED

*Handwritten signature*

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*Handwritten signature*

**1** **INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11433

11418

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>MD.</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Lonacening</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS <u>Union Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Cecilia</u> (Middle) <u>Jones</u> (Last)				Dec, 25 1955			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Female</u>		<u>White</u>		<u>Widowed</u>		<u>Jan, 23, 1889</u>	
						<b>9. AGE last birthday</b> <u>66</u> yrs.	
						IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>General Textile Mill</u>						<u>Barton, MD.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<u>U.S.</u>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Sherman Crable</u>				<u>Jennie Shonskey</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>				<u>2160 05-5886</u>		<u>Mrs. Jennie Graham, (DAUGHTER)</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b> <u>Lonacening, MD.</u>	
<b>420.1 IMMEDIATE CAUSE (A)</b> <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Coronary Occlusion</u>						<u>24 hr.</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>Atherosclerosis</u>						<u>2 yr.</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>July 25, 1953</u> , <b>to</b> <u>Dec 25, 1953</u> , <b>that I last saw the deceased</b> <u>alive on</u> <u>Dec 25, 1953</u> , <b>and that death occurred at</b> <u>8:00 A.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>George Richards</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Lonacening, Md. 12-27-55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>Dec, 28, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Memorial Park</u>	
						<b>LOCATION (City, town, or county) (State)</b> <u>Frostburg, MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Dec. 28, 1955</u>		<u>Walter R. Raab, M.D.</u>		<u>George Eichhorn, Lonacening, MD.</u>			

# 11418 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "35"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1900"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
DATE OF DEATH [Faint text, possibly "Dec 20, 1935"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	

BUREAU V. S.

DEC 20 1935

RECEIVED

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11419

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN <u>Cumberland</u>		80 yrs.		Cumberland		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 840 Maryland, Ave.				840 Maryland, Ave.			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) Margaret (Middle) Isabel (Last) Judy				12/2/55 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Widowed	3/2/1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housekeeper at Home					Cumberland, Md.		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James Keady				Mary Roller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
4 no		none		Gladys Judy Cumberland, Md.			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A)				Criteria of Coronary Disease			
ANTECEDENT CAUSE(S) DUE TO				Vascular disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				INTERVAL BETWEEN ONSET AND DEATH			
				to 2005x			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 2, 1955, to 12.12.1955, that I last saw the deceased alive on Nov 29, 1955, and that death occurred at 10:10 P.M. from the causes and on the date stated above.							
SIGNATURE <u>W. F. Williams M.D.</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>12.5.55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/5/55		Hillcrest Cemetery		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Dec. 5, 1955		Walter R. Fantz, M.D.		H. Lee Silcox		Cumberland, Md.	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# CERTIFICATE OF DEATH

Reg. One. 18

1. NAME OF DECEASED (PRINT OR TYPE)

MARYLAND

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. SEX

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CLERK

24. SIGNATURE OF DEPUTY CLERK

25. SIGNATURE OF ASSISTANT CLERK

26. SIGNATURE OF RECEPTIONIST

27. SIGNATURE OF TELEPHONE OPERATOR

28. SIGNATURE OF MAIL ROOM CLERK

29. SIGNATURE OF RECORDS CLERK

30. SIGNATURE OF CHIEF CLERK

31. SIGNATURE OF DEPUTY CHIEF CLERK

32. SIGNATURE OF ASSISTANT CHIEF CLERK

33. SIGNATURE OF RECEPTIONIST

34. SIGNATURE OF TELEPHONE OPERATOR

35. SIGNATURE OF MAIL ROOM CLERK

36. SIGNATURE OF RECORDS CLERK

37. SIGNATURE OF CHIEF CLERK

38. SIGNATURE OF DEPUTY CHIEF CLERK

39. SIGNATURE OF ASSISTANT CHIEF CLERK

40. SIGNATURE OF RECEPTIONIST

41. SIGNATURE OF TELEPHONE OPERATOR

42. SIGNATURE OF MAIL ROOM CLERK

43. SIGNATURE OF RECORDS CLERK

44. SIGNATURE OF CHIEF CLERK

45. SIGNATURE OF DEPUTY CHIEF CLERK

46. SIGNATURE OF ASSISTANT CHIEF CLERK

47. SIGNATURE OF RECEPTIONIST

48. SIGNATURE OF TELEPHONE OPERATOR

49. SIGNATURE OF MAIL ROOM CLERK

50. SIGNATURE OF RECORDS CLERK

51. SIGNATURE OF CHIEF CLERK

52. SIGNATURE OF DEPUTY CHIEF CLERK

53. SIGNATURE OF ASSISTANT CHIEF CLERK

54. SIGNATURE OF RECEPTIONIST

55. SIGNATURE OF TELEPHONE OPERATOR

56. SIGNATURE OF MAIL ROOM CLERK

57. SIGNATURE OF RECORDS CLERK

58. SIGNATURE OF CHIEF CLERK

SHORTLY AFTER

NOV 11 1955

*Antonia Delicate Card*  
*Van Buren Avenue*

BUREAU V. 1

EC 6 1955

RECEIVED

11435

11420

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland, Md.</u>		<u>4 days</u>		TOWN <u>Jennings, Md.</u>		<u>11X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crump Convalescent Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOSEPH WILLIAM KEEFE</u>				<u>Dec. 16 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>April 29, 1878</u>	<u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired manager</u>		<u>Hotel</u>		<u>Towanda, Pa.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Keefe</u>				<u>Sara Schrivins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>312-24-0498</u>		<u>Mrs Gleaves Knecht, Salisbury, Pa.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>260X</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 16</u> , 19 <u>55</u> , to <u>Dec 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>55</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leonard L. Rock</u>				ADDRESS (Street, city, town, state) <u>209 North St. Meyersdale Pa</u>			
DATE SIGNED <u>12/17/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/19/55</u>		<u>Grantsville</u>		<u>Grantsville, Garrett Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec 19 1955</u>		<u>Winter L. Frantz, M.D.</u>		<u>Ronald J. Newman</u>		<u>Grantsville, Md.</u>	

## INSTRUCTIONS

1. Without certificate limits

2. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

3. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10

BUREAU V. S.

DEC 21 1955

RECEIVED

431 E

10-11-1901

11436

# 11421 CERTIFICATE OF DEATH

Item 9, FilmG191 1-12-56 et Item 4, FilmG191 1-20-56 et

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>415 N. Centre St.</u>		STREET ADDRESS (If rural give location) <u>415 N. Centre St.</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Emma Young Keller</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 27 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1/28/1876</u>	
9. AGE last birthday <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis H Young</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Koegel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Lloyd Mobus Cumberland, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arterio Sclerotic</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Vascular Disease</u> STATING UNDERLYING CAUSE LAST.				Interval between onset and death <u>Sudden</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12.26. 1955</u> , to <u>12.26. 1955</u> , that I last saw the deceased alive on <u>12.26. 1955</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. Williams</u> M.D. <u>Cumberland</u>				ADDRESS (Street, city, town, state) <u>12/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Mausoleum</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>Dec 29, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

FILED

2. JURISDICTION (COUNTY OF) OF RECORD

3. PLACE OF DEATH

4. DECEASED  
 NAME  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 MARITAL STATUS  
 COLOR

5. DEATH  
 DATE  
 TIME  
 PLACE  
 CAUSE  
 MANNER

6. MEDICAL HISTORY  
 PREVIOUS ILLNESS  
 PREVIOUS SURGERY  
 PREVIOUS TRAUMA  
 PREVIOUS DRUGS  
 PREVIOUS ALCOHOL

7. PHYSICIAN  
 NAME  
 ADDRESS  
 CITY  
 STATE  
 ZIP

8. CORONER  
 NAME  
 ADDRESS  
 CITY  
 STATE  
 ZIP

9. FUNERAL HOME  
 NAME  
 ADDRESS  
 CITY  
 STATE  
 ZIP

10. BURIAL  
 NAME  
 ADDRESS  
 CITY  
 STATE  
 ZIP

11. SIGNATURE OF DECEASED  
 NAME  
 ADDRESS  
 CITY  
 STATE  
 ZIP

12. SIGNATURE OF WITNESS  
 NAME  
 ADDRESS  
 CITY  
 STATE  
 ZIP

13. SIGNATURE OF REGISTRAR  
 NAME  
 ADDRESS  
 CITY  
 STATE  
 ZIP

DECLARATION

STATE OF MASSACHUSETTS, COUNTY OF SUFFOLK, I, the undersigned, Registrar of the State Department of Health, do hereby certify that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the State Department of Health.

BUREAU V. S.

DEC 30 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11437

Within corporate limits  
11422

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>ALLEGANY</b>		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cumberland</b>		LENGTH OF STAY (in this place) <b>2/23/54</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Westernport</b>		<b>43</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Allegany County Infirmary</b>		STREET ADDRESS (If rural give location) <b>106 Oak View Drive</b>				<b>1</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>Rosa Fearon Kelly</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>December 8, 1955</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 2, 1873</b>	9. AGE last birthday <b>82</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Neury, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Francis Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Fearon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Allegany County Infirmary Records</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>				<b>18 hrs.</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Myocardial Degeneration</b>				<b>?</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Cerebral Arteriosclerosis</b>				<b>?</b>			
2608 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Diabetes Mellitus</b>				<b>?</b>			
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb. 23, 1954</b> , to <b>Dec. 8th, 1955</b> , that I last saw the deceased alive on <b>Dec. 7th, 1955</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>James E. McLean</b> M.D.				ADDRESS (Street, city, town, state) <b>44 Greene St.</b>		DATE SIGNED <b>12-8-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-10-55</b>		NAME OF CEMETERY OR CREMATORY <b>St. Gabriel Cem.</b>		LOCATION (City, town, or county) (State) <b>Barton Md.</b>	
24. REC'D BY REGISTRAR DATE <b>12-8-55</b>		REGISTRAR'S SIGNATURE <b>Arthur R. Drantz, m.d.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth S. Boal</b>		ADDRESS <b>Westernport</b>	

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11423

# CERTIFICATE OF DEATH

11438

DR. HODGES

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN CUMBERLAND		4 DAYS		TOWN CUMBERLAND		02	
60 HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 29 MAPLE STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARTHA		(Middle) E.		(Last) KIDWELL		(Day) 15, (Year) 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	SEPTEMBER 14 1889	66 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		Cura Home		PAW PAW, W. VA.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES W. RUDY				MARY HUTCHINSON,			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
None		None		MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170x IMMEDIATE CAUSE (A)				Carcinoma Right breast & axilla			
ANTECEDENT CAUSE(S) DUE TO				Circulatory collapse			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				post operative			
STATING UNDERLYING CAUSE LAST. DUE TO (C)				36 hrs			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
12/15/55		Carcinoma R. breast & axill. glands		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 6, 1955, to Dec 15, 1955, that I last saw the deceased alive on Dec 15, 1955, and that death occurred at 3:20 AM, from the causes and on the date stated above.							
SIGNATURE W. R. Hodges				ADDRESS (Street, city, town, state) Cumberland, Md.			
M.D.				DATE SIGNED 12/15/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec 17, 1955		Woodrow Union Cemetery		Woodrow W. Va	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Dec. 17, 1955		Winter R. Frantz, M.D.		John J. Hafer - Cumberland, Md.			

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BUREAU V. S.

DEC 18 1955

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11424

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY ALLEGANY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN CUMBERLAND

LENGTH OF STAY (in this place)

1 mon. 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN CUMBERLAND

STREET ADDRESS

(If rural give location)

13 FREDERICK STREET

## 3. NAME OF DECEASED (Type or Print)

(First)

(Middle)

(Last)

GRACE

COMPTON

KNIPP

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

12-1-55

19

## 5. SEX

F

## 6. COLOR OR RACE

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widow

## 8. DATE OF BIRTH

Nov. 27, 1884

## 9. AGE last birthday

71

yrs.

## IF UNDER 1 YEAR

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

Own Home

## 11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Joseph Wilkinson

## 14. MOTHER'S MAIDEN NAME

Hattie Rawlings

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT &amp; ADDRESS

Lester Wilkinson, Cumb., Md.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

## IMMEDIATE CAUSE

(A)

① Congestive Heart Failure

## ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

③ Myocardial Infarction, acute

(C)

② Pneumonia, Bronchial

260x OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

④ Coronary Sclerosis  
Diabetes mellitus + Obesity

## 18. MEDICAL CERTIFICATION

## INTERVAL BETWEEN ONSET AND DEATH

8 days

61 days

8 days

?

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒

## 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While et work ☐ Not while et work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 Oct 1955, to 1 Dec 1955, that I last saw the deceased alive on 30 Nov 1955, and that death occurred at 7:00 PM, from the causes and on the date stated above.

## SIGNATURE

Annelle G. Weisauer, M.D.

## ADDRESS (Street, city, town, state)

59 Green St Cumberland

## DATE SIGNED

1 Dec 56

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

Burial

Dec. 3, 1955

Rose Hill Cem.

Cumberland, Md.

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

Dec. 3, 1955

Walter L. Hafer, M.D.

John J. Hafer

John J. Hafer, Cumb., Md.

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



BUREAU V. S.

DEC 9 1965

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 9

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL and give nearest town)	Vale Summit		CITY (If outside corporate limits write RURAL and give nearest town)	Tow(rural) Vale Summit	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	R.F.D.#1 Frostburg, Md.		STREET ADDRESS	(If rural, give location) R.F.D.#1 Frostburg, Md.	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	William	De Sales	Leake	Dec.	3 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
male	white	married	May 31-1891	64 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, Retired)	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
Miner	Coal		Vale Summit, Md.	U.S.A.	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
John Leake			Jane Horthorne		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
yes W.W.1		216-09-8224	(wife) Mary Leake, Vale Summit, Md.		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			sudden
812X Immediate cause (a) Intracranial hemorrhage DUE TO Antecedent cause(s) (b) fractured skull also had lower left leg fractured Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c) Hit by an auto.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg, etc., INJURY route 155	21c. (City or town) (County) (State)	Vale Summit Allegany 01 Md.
21d. TIME (Month) (Day) (Year) OF INJURY Dec. 3-1955 P. M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Walking on road and was hit by an automobile.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <input checked="" type="checkbox"/> Dec. 5-1955 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-6-55	St. Michael	Frostburg, Allegany, Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
12-6-55	Mr. Nancy N. Roe	Joseph R. Dunsen Frostburg, Md.	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11441

11425

Without corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MIDDLE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Cumberland</u>		<u>35 yrs</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>312 Frederick Street</u>				STREET ADDRESS (If rural give location) <u>312 Frederick Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>CHARLES</u> (Middle) <u>HENRY</u> (Last) <u>LEE Jr.</u>				(Month) <u>December</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 10, 1898</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Odd Jobs</u>	11. BIRTHPLACE (State or foreign country) <u>Lynchburg, Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>CHARLES HENRY LEE, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>MARY LEFRAGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>W. W. I.</u>		16. SOCIAL SECURITY NO. <u>218-30-0563</u>		17. INFORMANT & ADDRESS <u>Mrs. Sally Lee, Cumberland, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>492X</u> <u>Vincent's Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial, Arterial degeneration</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>None</u>							
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>12/28</u> , 19 <u>55</u> , to <u>Dec 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above <u>12/9/55</u>							
SIGNATURE <u>L. H. Green</u>				ADDRESS (Street, city, town, state) <u>49 Green St. Cumberland, Md.</u> DATE SIGNED <u>12/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 9, 1965</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Hunt, Md.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Md.</u>	
DATE <u>Dec 9, 1955</u>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

11159

Reg. No. 11159

1. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)

2. SEX AND AGE

3. OCCUPATION

4. CAUSE OF DEATH

5. DATE OF DEATH

6. PLACE OF DEATH

7. SIGNATURE OF PHYSICIAN

8. SIGNATURE OF REGISTRAR

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF DEATH CERTIFICATE

11. SIGNATURE OF DEATH CERTIFICATE

12. SIGNATURE OF DEATH CERTIFICATE

13. SIGNATURE OF DEATH CERTIFICATE

14. SIGNATURE OF DEATH CERTIFICATE

15. SIGNATURE OF DEATH CERTIFICATE

16. SIGNATURE OF DEATH CERTIFICATE

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BUREAU V. B.

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EMERGENCY

THIS CERTIFICATE IS TO BE USED IN CASES OF DEATHS OCCURRING IN THE CITY OF BALTIMORE, MARYLAND, AND IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED, OR BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, IN CASES OF DEATHS OCCURRING IN THE CITY OF BALTIMORE, MARYLAND, AND IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED, OR BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, IN CASES OF DEATHS OCCURRING IN THE CITY OF BALTIMORE, MARYLAND.



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11442

11426

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>				TOWN <u>Nikep</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cleveland Ave.</u>				STREET ADDRESS (If rural give location) <u>-----</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>THOMAS</u> <u>LEE</u>				<u>Dec.</u> <u>25</u> <u>19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>April, 12. 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>Retired Coal Miner</u>			<u>Coal Mine</u>		<u>Westernport, Md.</u>		<u>U.S.A.</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Henry Lee</u>				<u>Ellen Foley</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>179-03-4997</u>		<u>Henry Lee, Cumberland, MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b> (SON)		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>447X</u> IMMEDIATE CAUSE (A) <u>Hypertensive Arteriosclerosis</u>				<u>One</u>		<u>year.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>12-25, 1955</u>, to <u>12-25, 1955</u>, that I last saw the deceased alive on <u>12-25, 1955</u>, and that death occurred at <u>9a</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>W. F. Williams</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Cumberland Alleg.</u>		<b>DATE SIGNED</b> <u>12-27-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>Dec, 28, 1955</u>		<u>Laurel Hill Cemetery, Moscow</u>		<u>MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS			
<u>Dec. 28, 1955</u>		<u>Walter R. Hantz M.D.</u>		<u>George Eichhorn, Lenoxing, MD.</u>			

RECEIVED

DEC 29 1955

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. DATE OF DEATH  
9. PLACE OF DEATH  
10. CAUSE OF DEATH  
11. SIGNATURE OF PHYSICIAN  
12. SIGNATURE OF REGISTRAR  
13. SIGNATURE OF WITNESSES  
14. SIGNATURE OF DECEASED  
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16. SIGNATURE OF CLERK  
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20. SIGNATURE OF SECRETARY  
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98. SIGNATURE OF SECRETARY  
99. SIGNATURE OF ASSISTANT SECRETARY  
100. SIGNATURE OF CLERK

Replacement cert. 1/9/56 ans  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

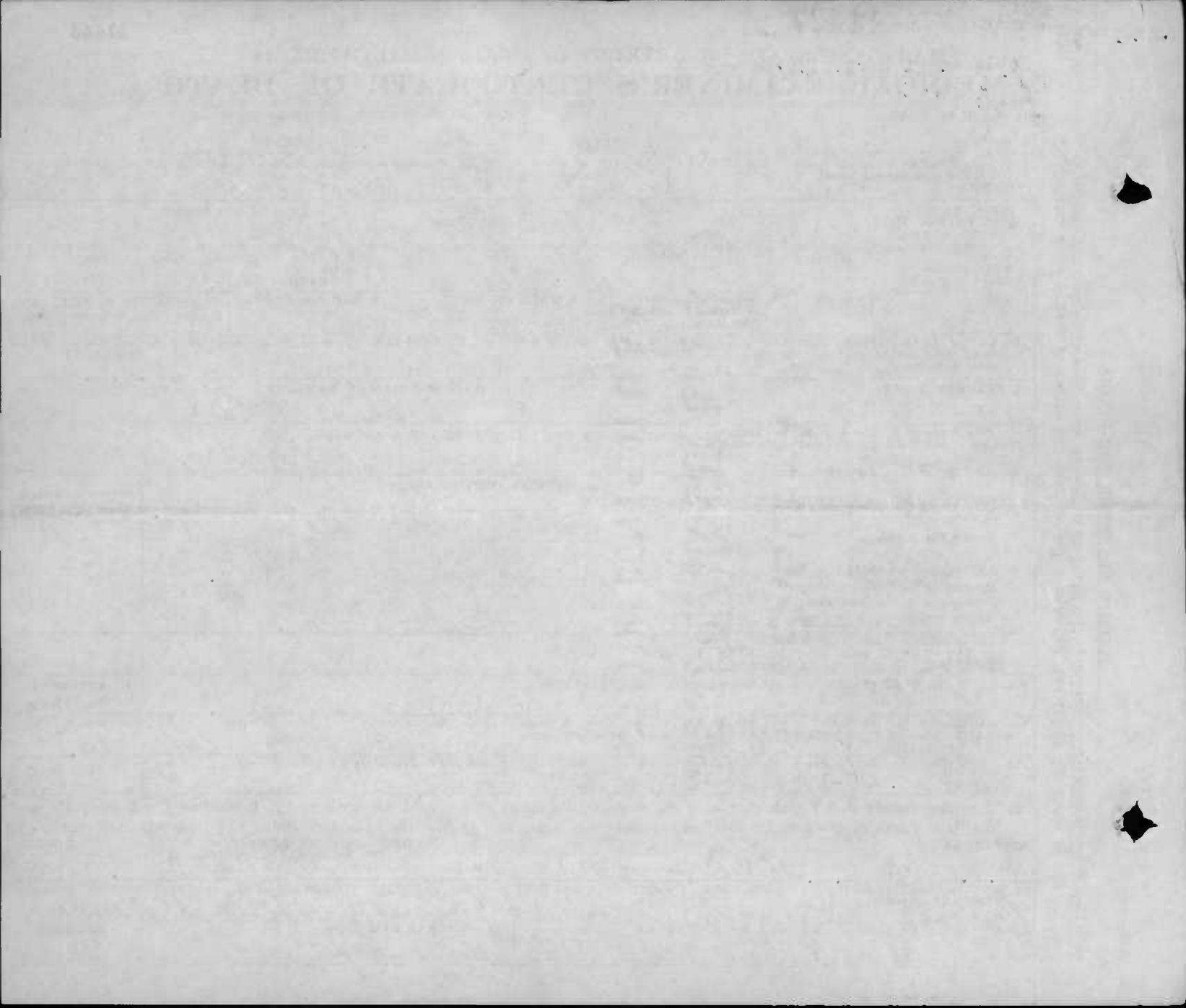
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Allegany	STATE	Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Cumberland	CITY (If outside corporate limits write RURAL and give nearest town)	Cumberland
TOWN	Cumberland	TOWN	Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Memorial Hospital	STREET ADDRESS	819 Fredrick St.
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
(Type or Print)	Mary	Ellen	Loy
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Female	white	widow	Nov. 27-1883
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	housewife	10b. KIND OF BUSINESS OR INDUSTRY:	own home
11. BIRTHPLACE (State or foreign country):	Ellerslie, Md.	12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Lemmert Wilger		Sophia Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
4 no		none	
17. INFORMANT & ADDRESS:		Memorial Hospital records.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		3 days
(a) Immediate cause		
Probable cerebral hemorrhage due to hypertension		
(b) Antecedent cause(s)		
DUE TO Probable cerebral hemorrhage due to a probable fractured skull, fell to floor.		
(c) also had a cardio-vascular disease.		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
	Autopsy refused by family.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home	21c. (City or town) (County) (State)
	Cumberland Allegany Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 29-1955 P.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Dizzy, fell to the floor, striking on left side of face.
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .		
SIGNATURE		
H. V. Deming M.D. H. V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. DATE SIGNED Dec. 31-1955		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	LOCATION (City, town, or county) (State)
Burial	Jan. 2, 1956	Shannon Cemetery, Cumberland, Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan. 4, 1956	Walter R. Frank, M.D.	John J. Saffer

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 11428 CERTIFICATE OF DEATH

11444

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>1 DAY</u>		TOWN <u>CUMBERLAND, MD.</u>		<u>RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>				STREET ADDRESS <u>POTOMAC PARK, R.F.D. #6,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>VICKIE</u>		(Middle) <u>L</u>		(Last) <u>MACKERETH</u>		(Month) <u>DEC.</u> (Day) <u>26</u> (Year) <u>55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>7-5-55</u>	<u>5</u> yrs.	Months <u>5</u>	Days <u>21</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Cumberland, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CHESTER W. MACKERETH</u>				<u>GLORIA E. MEYERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>MEMORIAL HOSPITAL</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>25 Dec</u> , 19 <u>55</u> , to <u>26 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>26 Dec</u> , 19 <u>55</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas Robinson</u>				ADDRESS (Street, city, town, state) <u>M.D. 2325 Liberty St. Cumberland, Md.</u>		DATE SIGNED <u>27 Dec 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-29-55</u>		<u>Davis Memorial</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 28, 1955</u>		<u>Walter R. Fautz, M.D.</u>		<u>James F. Scarpelli</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2075262363



# 11-288 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

2. SEX

3. AGE

4. MARRIAGE

5. OCCUPATION

6. RACE

7. BIRTH

8. DEATH

9. CAUSE

10. PLACE

11. TIME

12. DATE

13. SIGNATURE

14. NAME

15. ADDRESS

16. CITY

17. STATE

18. COUNTY

19. ZIP

20. TELEPHONE

21. HOSPITAL

22. PHYSICIAN

23. NURSE

24. CORONER

25. JUDGE

26. CLERK

27. DEATH

28. CAUSE

29. SIGNATURE

30. NAME

31. ADDRESS

32. CITY

33. STATE

34. COUNTY

35. ZIP

36. TELEPHONE

37. HOSPITAL

38. PHYSICIAN

39. NURSE

40. CORONER

41. JUDGE

42. CLERK

43. DEATH

44. CAUSE

45. SIGNATURE

46. NAME

47. ADDRESS

48. CITY

49. STATE

50. COUNTY

51. ZIP

52. TELEPHONE

53. HOSPITAL

54. PHYSICIAN

55. NURSE

56. CORONER

57. JUDGE

58. CLERK

59. DEATH

60. CAUSE

61. SIGNATURE

62. NAME

63. ADDRESS

64. CITY

65. STATE

66. COUNTY

67. ZIP

68. TELEPHONE

69. HOSPITAL

70. PHYSICIAN

71. NURSE

72. CORONER

73. JUDGE

74. CLERK

75. DEATH

76. CAUSE

77. SIGNATURE

RECEIVED

BUREAU V. 8

DEC 29 1955

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11457

## CERTIFICATE OF DEATH

11445

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg,</u>		LENGTH OF STAY (in this place) <u>11 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg,</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miner's Hospital</u>				STREET ADDRESS (If rural give location) <u>66 Broadway</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Mary</u>		(Middle) <u>Jane</u>		(Last) <u>MacMannis</u>		(Day) (Month) (Year) <u>Dec. 10th, 19 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 13th, 1871</u>	9. AGE last birthday <u>84 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christopher Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Jane Boynes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.0 IMMEDIATE CAUSE (A) <u>arteriosclerotic Heart Disease - failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several Days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>age &amp; Hypertensive Heart Disease</u>				<u>Yrs -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Jan. 50, to Dec. 10, 19 55, that I last saw the deceased alive on Dec. 10, 19 55, and that death occurred at 10:35 P.M. from the causes and on the date stated above.</b>							
SIGNATURE <u>John B. Davis</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>12/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>12-13-55</u>		REGISTRAR'S SIGNATURE <u>M. Nancy N. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

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BUREAU V. S.

DEC 20 1955

RECEIVED

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11446

11429

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>02</u> <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>70</u> Years		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>414. Park Street</u>				STREET ADDRESS (If rural give location) <u>414. Park Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Thomas</u> <u>James</u> <u>Malamphy</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec</u> <u>21</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	B. DATE OF BIRTH <u>February 25 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Live stock dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buying &amp; selling</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Michael Ma lamphy</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Stanton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>3</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>213-22-3498</u>		17. INFORMANT & ADDRESS <u>Mrs. Blanche Mala mphy, Cumberland, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
502.1 IMMEDIATE CAUSE (A) <u>Chronic Bronchitis and Bronchietect</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Two years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Chronic Myocarditis</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-20</u> , to <u>12-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-20</u> , 19 <u>55</u> , and that death occurred at <u>10 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Walter L. Brantz</u>				DATE SIGNED <u>12-22-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 23 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter L. Brantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Knight</u> <u>Cumberland, Md.</u>			





## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11430

## CERTIFICATE OF DEATH

11447

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>35 yrs</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>46 Marion</u>				STREET ADDRESS (If rural give location) <u>46 Marion Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Francis Charles Mamajek</u>				<u>Dec. 2 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>m</u>	<u>W</u>	<u>Married</u>	<u>9/24/1897</u>	<u>58</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Boilermaker</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B&amp;O Railroad</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pittsburgh, Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>Charles Mamajek</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Zera</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>705-05-4512</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Cumberland, Md.</u> <u>Mrs. Francis Mamajek</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>154X IMMEDIATE CAUSE (A)</b> <u>Carcinomatosis</u>						<u>2 mo</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Carcinoma Rectum</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>Carcinoma Rectum</u>						<u>1 yr.</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>Feb 9, 1955</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>advanced carcinoma Rectum &amp; metastasis</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb 9, 1955</u>, to <u>Dec 2</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12-1-55</u>, 19<u>55</u>, and that death occurred at <u>7:30 P</u>.M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Cumberland Md</u>		<b>DATE SIGNED</b> <u>12-5-55</u>	
<b>23. BURIAL CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12/5/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Peters &amp; Pauls</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Cumberland Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Dec 5, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Walter R. Frank, M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. Lee Silcox</u> <b>ADDRESS</b> <u>Cumberland, Md.</u>			



## 11431 CERTIFICATE OF DEATH

11448

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>4yr. 11mo.</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sylvan Retreat</u>				<u>5 Grand Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Flossie</u> (Middle) <u>Myrtle</u> (Last) <u>Manges</u>				<u>December 27,</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Separated</u>	<u>September 25, 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Hyndman, Penn.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Evans</u>				<u>Elizabeth (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>John Manges, 16 Arch St. Cumb. (son)</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>422.2</u> IMMEDIATE CAUSE (A) <u>Pulmonary Hypostasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Osteo-arthritis.</u>				?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>undiagnosed psychosis</u>				<u>4 yr 11 mo</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1953</u> , 19....., to <u>Dec. 27</u> , 19....., that I last saw the deceased alive on <u>Dec. 27</u> , 19....., and that death occurred at <u>8:20 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>James E. McLean</u> M.D.				DATE SIGNED <u>12-28-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 30, 1955</u>		<u>Hyndman Cemetery</u>		<u>Hyndman, Pennsylvania.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 29, 1955</u>		<u>Walter R. Gantz, M.D.</u>		<u>James F. Scarpelli, Cumberland, Maryland.</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11466

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural-Cumberland</u>		<u>10 yrs.</u>		TOWN <u>Rural-Cumberland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 4, Oldtown Rd. Cumberland</u>				STREET ADDRESS (If rural give location) <u>Oldtown Road, Cumberland, Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Verdie</u> (Middle) <u>Ellen</u> (Last) <u>McBride</u>				(Month) <u>Dec.</u> (Day) <u>18</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>Oct. 16, 1868</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hampshire Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Abraham Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>George McBride, Rt. 4, Cumberland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Semile Cardio-Vascular Disease and Malnutrition</u>						<u>Unknown</u>	
DUE TO ANTECEDENT CAUSE(S) (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mass in left lower quadrant</u>						<u>Unknown</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 Dec., 1955</u> , to <u>19 Dec., 1955</u> , that I last saw the deceased alive on <u>15 Dec., 1955</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Carlton Brunsfield</u>				ADDRESS (Street, city, town, state) <u>232 Baltimore Ave.</u>		DATE SIGNED <u>12-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Three Churches W. Va.</u>	
24. REC'D BY REGISTRAR <u>Dec. 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Md.</u>	

## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11-4-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# CERTIFICATE OF DEATH

11-4-55

FILE NO.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE

11. DATE OF DEATH

12. TIME OF DEATH

13. PLACE OF DEATH

14. SIGNATURE

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. SIGNATURE

19. DATE OF DEATH

20. TIME OF DEATH

21. PLACE OF DEATH

22. SIGNATURE

23. DATE OF DEATH

24. TIME OF DEATH

25. PLACE OF DEATH

26. SIGNATURE

27. DATE OF DEATH

28. TIME OF DEATH

29. PLACE OF DEATH

30. SIGNATURE

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF DEATH

34. SIGNATURE

35. DATE OF DEATH

36. TIME OF DEATH

37. PLACE OF DEATH

38. SIGNATURE

39. DATE OF DEATH

40. TIME OF DEATH

41. PLACE OF DEATH

42. SIGNATURE

43. DATE OF DEATH

44. TIME OF DEATH

45. PLACE OF DEATH

46. SIGNATURE

47. DATE OF DEATH

48. TIME OF DEATH

49. PLACE OF DEATH

50. SIGNATURE

51. DATE OF DEATH

52. TIME OF DEATH

53. PLACE OF DEATH

54. SIGNATURE

55. DATE OF DEATH

56. TIME OF DEATH

57. PLACE OF DEATH

58. SIGNATURE

59. DATE OF DEATH

60. TIME OF DEATH

61. PLACE OF DEATH

62. SIGNATURE

63. DATE OF DEATH

64. TIME OF DEATH

65. PLACE OF DEATH

66. SIGNATURE

67. DATE OF DEATH

68. TIME OF DEATH

69. PLACE OF DEATH

70. SIGNATURE

71. DATE OF DEATH

72. TIME OF DEATH

73. PLACE OF DEATH

74. SIGNATURE

75. DATE OF DEATH

76. TIME OF DEATH

77. PLACE OF DEATH

78. SIGNATURE

79. DATE OF DEATH

80. TIME OF DEATH

81. PLACE OF DEATH

82. SIGNATURE

BUREAU V. S.

DEC 27 1955

RECEIVED

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11432

## CERTIFICATE OF DEATH

11450

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>CUMBERLAND,</b>		LENGTH OF STAY (in this place) <b>24 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>				STREET ADDRESS <b>RT. #5, Yacker Road</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>MRS ELIZABETH MC GILL</b>				<b>4. DATE OF DEATH</b> (Month) <b>DEC. 22</b> (Day) <b>1955</b> (Year)			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>WIDOWED</b>	<b>8. DATE OF BIRTH</b> <b>JULY 19, 1869</b>	<b>9. AGE last birthday</b> <b>86</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>WEST VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>JOHN HAINES</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>SARAH SMITH</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>464X IMMEDIATE CAUSE (A)</b> <b>Pulmonary Embolism</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>15 minutes</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>(B)</b> <b>Peripheral Vascular Disease</b>							
<b>(C)</b> <b>Phlebo-thrombosis</b>						<b>4 weeks</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Chronic Arterio Sclerotic Cardio Vascular Disease</b>						<b>4 years</b>	
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Dec 21, 1955, to Dec 22, 1955, that I last saw the deceased alive on Dec 21, 1955, and that death occurred at 4:00PM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>John C. Topper</b>				<b>DATE SIGNED</b> <b>12/24/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>Dec. 26, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Pleasant Meth. Cem</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Dec. 26, 1955</b>				<b>REGISTRAR'S SIGNATURE</b> <b>Walter R. Brantzy, M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John J. Hafer, Cumberland, Md</b>	

# CERTIFICATE OF DEATH

How Died No.

1. USUAL PLACE OF DEATH

2. SEX ☐ MALE ☐ FEMALE

3. RACE

4. AGE

5. DAYS

6. MONTH

7. YEAR

8. DATE OF DEATH

9. TIME

10. PLACE

11. SEX

12. RACE

13. AGE

14. MONTH

15. YEAR

16. U.S.A.

17. WEST VIRGINIA

18. SARAH SMITH

19. JOHN SMITH

20. DEATH CERTIFICATE, DECEASED, N.Y.

*Signature of Physician*  
*Signature of Registrar*  
*Signature of Coroner*

BUREAU V. S.

RECEIVED  
 DEC 28 1922

SMITH SMITH

*Signature of Registrar*

# 11433 CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>15 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>407 Fayette St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Naomi Meade</u>				<u>12 - 23 - 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Negro</u>	<u>Married</u>	<u>2-3-07</u>	<u>48</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>Own House</u>		<u>Maryland Cumberland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Parker</u>				<u>Stella Weadon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>None</u>		<u>Carl Meade Cumberland, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							<u>10 hours</u>
584X IMMEDIATE CAUSE (A) <u>pulmonary embolism</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>after cholecystectomy and drainage for</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>empyema of gallbladder</u>							<u>2 weeks</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>12-10-55</u>		<u>empyema of gallbladder, 1st and 2nd gallbladder neck, diseased</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-10-55</u> , to <u>12-23-55</u> , that I last saw the deceased alive on <u>12-22-55</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>57 Greene St. Cumberland Md.</u>		DATE SIGNED <u>12-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>Dec 28 1955</u>	<u>St. Peter &amp; Paul Cem</u>		<u>Cumberland Md.</u>		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec 27, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>[Signature]</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. S.

DEC 28 1955

RECEIVED



11434

11452  
Reg. Dist.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland  
 TOWN Cumberland LENGTH OF STAY (in this place) 1 yr.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 917 Virginia Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
 CITY (If outside corporate limits write RURAL and give nearest town) Cumberland  
 TOWN Cumberland

STREET ADDRESS (If rural, give location) 917 Virginia Ave.

## 3. NAME OF DECEASED: (First) (Middle) (Last)

(Type or Print) James W. Mercure Sr.

## 4. DATE OF DEATH (Month) (Day) (Year)

Dec. 7 19 55

## 5. SEX:

Male

## 6. COLOR OR RACE:

white

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

## 8. DATE OF BIRTH:

Aug. 7-1910

## 9. AGE last birthday:

45 yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, if known)

Brakeman

## 10b. KIND OF BUSINESS OR INDUSTRY:

B&O.R.Ry.

## 11. BIRTHPLACE (State or foreign country):

Corinth, W.Va.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Michael Mercure

## 14. MOTHER'S MAIDEN NAME:

Rose Grimes

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY No.:

234-12-0996

## 17. INFORMANT &amp; ADDRESS:

Records in his room.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a) DUE TO

Myocardial infarction

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

coronary occlusion.

(c)

INTERVAL BETWEEN ONSET AND DEATH

sudden

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

1

## 20. AUTOPSY?

Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

## 21c. (City or town)

(County)

(State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
 DEPUTY MEDICAL EXAMINER ☒  
 ASSISTANT MEDICAL EXAM. ☐

Dec. 7-1955

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

## DATE THEREOF

12-10-55

## NAME OF CEMETERY OR CREMATORY

Sanders Cem.

## LOCATION (City, town, or county)

Near Tunnelton, W.Va.

(State)

## DATE REC'D BY LOCAL REG.

12-9-55

## REGISTRAR'S SIGNATURE

Hunter R. Grant, M.D.

## 24. FUNERAL DIRECTOR

James F. Scarpelli

## ADDRESS

Cumberland, Md

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1935

RECEIVED

1

## 11457 CERTIFICATE OF DEATH

Reg. Dist. No. 6

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Luke</u>		<u>40 years</u>		TOWN <u>Luke M</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pratt Street</u>				STREET ADDRESS (If rural give location) <u>Pratt Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>CARL</u>		(Middle) <u>GILLEAD</u>		(Last) <u>MILLER</u>		(Month) (Day) (Year) <u>Dec 11 19 55</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>21 July 1908</u>		<u>47</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Merchant</u>		<u>Grocery</u>		<u>Bloomington, Maryland</u>		<u>US</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Oliver G. Miller</u>				<u>Florence Duckworth</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>236-03-3999</u>		<u>Mrs Mary Lee Miller, Luke, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>UNDERLYING CAUSE LAST</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>0</u>							
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<input type="checkbox"/>							
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
		<input type="checkbox"/> <input type="checkbox"/>					
<b>22. I hereby certify that I attended the deceased from <u>Dec 10</u>, 19<u>55</u>, to <u>Dec 11</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec 11</u>, 19<u>55</u>, and that death occurred at <u>2:30 P.M.</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James A. Green</u>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
				<u>M.D. Green Street, Piedmont, W. Va.</u>		<u>12/11/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THERE OF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>12-14-55</u>		<u>Mount Lawn Cemetery</u>		<u>Raliegh, North Carolina</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>DATE 12-12-55</u>		<u>Mr. Jean C Kelly</u>		<u>Ed. Boral</u>		<u>Westernport, Md.</u>	



## 11435 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY ALLEGANY

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN CUMBERLANDLENGTH OF STAY  
(In this place)  
9 DAYSHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS MEMORIAL HOSPITAL

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY

ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN CUMBERLANDSTREET  
ADDRESS 451 HENDERSON AVE.3. NAME OF  
DECEASED  
(Type or Print)

(First)

ELLSWORTH

(Middle)

C.

(Last)

MYERS

4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

DEC. 8 18

19 55

5. SEX  
MALE6. COLOR OR  
RACE  
WHITE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) MARRIED

8. DATE OF BIRTH

11/17/1892

9. AGE last birthday

53 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Foreman

10b. KIND OF BUSINESS  
OR INDUSTRY

CRYSTAL LAUNDRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH

MYERS

14. MOTHER'S MAIDEN NAME

ELLA M. SIGLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-05-4538

17. INFORMANT &amp; ADDRESS

MEMORIAL HOSPITAL, MEMORIAL AVE.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

540.1 IMMEDIATE CAUSE (A)

Pyloric obstruction

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO

gastric ulcer with necrosis and scarring

(C)

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.INTERVAL BETWEEN  
ONSET AND DEATH

Sev. weeks.

Sw. Years.

19a. DATE OF OPERATION

15 Dec 55

19b. MAJOR FINDINGS OF OPERATION

Pyloric obstruction due to large gastric ulcer

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

While ☐ Not while ☐  
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 Dec 1955, to 18 Dec 1955, that I last saw the deceased  
alive on 17 Dec 1955, and that death occurred at 8:50 A.M. from the causes and on the date stated above.

SIGNATURE

Curtis Brumfield M.D.

M.D.

232 Baltimore Ave. Cumberland Md

ADDRESS (Street, city, town, state)

DATE SIGNED

18 Dec 55

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
Burial

DATE THEREOF

Dec 21 1955

NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

LOCATION (City, town, or county)

Cumberland, Md

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Dec 19, 1955 Walter R. Frantz, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

William H. Kight, Cumberland, Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11-1-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# 11333 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF BIRTH		2. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
3. SEX		4. RACE	
MALE		WHITE	
5. DATE OF BIRTH		6. DATE OF DEATH	
JAN 1 1900		DEC 21 1955	
7. AGE		8. CAUSE OF DEATH	
55 YEARS		HEART DISEASE	
9. MANNER OF DEATH		10. SIGNATURE OF DECEASED	
NATURAL			
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CORONER		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF BURIAL OFFICER		16. SIGNATURE OF INTERMENT OFFICER	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF MINISTRY	
21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER	
23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER	
27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER	
35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER	
39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
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63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER	
65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
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81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER	
83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER	
87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER	
89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER	
95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER	
99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

BUREAU V. S.

DEC 21 1955

RECEIVED

11468

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11455  
Reg. Dist.

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 X CITY (If outside corporate limits, write RURAL OR and give nearest town) RURAL  
Cumberland LENGTH OF STAY (in this place) 32 years  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#3 Bowmans Addition

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
 CITY (If outside corporate limits write RURAL and give nearest town) RURAL  
Cumberland STREET ADDRESS (If rural, give location) R.F.D.#3 Bowmans Addition

3. NAME OF DECEASED:

(First) Walter (Middle) Scott (Last) Nicewarner

4. DATE OF DEATH Dec. 19 55

5. SEX:

male

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower

8. DATE OF BIRTH:

June 20-1869

9. AGE last birthday: 86 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer - Cumberland Cement Company

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (State or foreign country): Harpers Ferry, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

John T. Nicewarner

14. MOTHER'S MAIDEN NAME:

Maggie Mattie Marsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: R.F.D.#3 Md  
Granddaughter Mrs. Wm. Boyd, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
 Immediate cause (a) Coronary occlusion  
 DUE TO

Antecedent cause(s) (b) Arteriosclerosis.  
 Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH  
sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐ , Inspection ☒ , Inquiry ☒ , and find that death resulted from: Natural causes ☒ , Accident ☐ , Suicide ☐ , Homicide ☐ , Undetermined cause ☐ .

SIGNATURE

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
 DEPUTY MEDICAL EXAMINER ☒  
 ASSISTANT MEDICAL EXAM. ☒

Dec. 19-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Dec. 20, 1955 Walter R. Hantz M.D. John J. Hager, Cumberland, Maryland

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Outside of City Limits

BUREAU V. S.

DEC 27 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

11456

2411 N. Charles Street, Baltimore

11469

## CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland Allegany</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Star Route Hancock Md.</u> LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Star Route Hancock Md.</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural, give location) <u>Star Route Hancock Md.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>James</u> <u>Albert</u> <u>Potts</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>6</u> <u>19 55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 5 1884</u>
9. AGE last birthday <u>71</u> yrs. <u>2</u> Months <u>1</u> Days		10. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Allegany County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jonas Potts</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Keefer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Mrs Margaret F Potts Star Route Hancock Md.</u>	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 19 38, 19....., to 12/3/55, 19....., that I last saw the deceasedalive on Nov 22 19 53, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12-10-55</u>	NAME OF CEMETERY OR CREMATORY <u>St Patricks Cemetery</u>	LOCATION (City, town, or county) <u>Little Orleans Md.</u>	(State) <u>Md.</u>
---	---------------------------------	--	---	-----------------------

DATE REC'D BY LOCAL REG. <u>12/10/55</u>	REGISTER'S SIGNATURE <u>J. H. Keller</u>	24. FUNERAL DIRECTOR <u>Howard J. Stone Hancock Md.</u>	ADDRESS
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MARGIN RESERVED FOR BANDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

DEC 13 1955

RECEIVED

*[Faint handwritten signature and date]*  
12/13/55



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11457

## 11436 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

02 TOWN Cumberland,

LENGTH OF STAY  
(in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland,

STREET  
ADDRESS

(If rural give location)

6 Virginia Ave.,

3. NAME OF  
DECEASED  
(Type or Print)

(First)

JAMES

(Middle)

DAVID

(Last)

PUGH

4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

Dec.

9,

19 55

## 5. SEX

Male

6. COLOR OR  
RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Married

## 8. DATE OF BIRTH

Feb. 6, 1910

## 9. AGE last birthday

45

yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Taxi driver

10b. KIND OF BUSINESS  
OR INDUSTRY

Yellow Top Cab.

## 11. BIRTHPLACE (State or foreign country)

Salem, W. Va.

12. CITIZEN OF WHAT  
COUNTRY?

U. S.

## 13. FATHER'S NAME

James L. Pugh

## 14. MOTHER'S MAIDEN NAME

Ethel Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

No,

## 16. SOCIAL SECURITY NO.

655-07-3130

## 17. INFORMANT &amp; ADDRESS

Mrs. Audra Pugh 6 Va. Ave., Cumb. Md.

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 IMMEDIATE CAUSE (A)

(A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

(C)

## 18. MEDICAL CERTIFICATION

Anemia

Chronic Myocarditis

Chronic Nephritis

INTERVAL BETWEEN  
ONSET AND DEATH

3 mos

6 yrs

4 yrs

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

## 21e. INJURY OCCURRED

White ☐ Not white ☐M. of work ☐ Not white ☐ of work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1950, to Dec. 9, 1955, that I last saw the deceased

alive on Dec. 9, 1955, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

## SIGNATURE

Clay B. Surrency

M.D.

## ADDRESS (Street, city, town, state)

Cumberland

## DATE SIGNED

12/10/55

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

12/12/55

## NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

## LOCATION (City, town, or county)

Cumberland, Maryland

## (State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

Walter R. Frantz, M.D.

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

Charles L. George Cumberland, Md.

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Form No. 1

1. USUAL RESIDENCE OF DECEASED

MARYLAND

ALLEGANY

BRIDGEVIEW

BRIDGEVIEW

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BUREAU V. S.

DEC 14 1955

RECEIVED

## 11437 CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>3yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>I05 5th St</u>				STREET ADDRESS (If rural give location) <u>I05 5th St.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Eliza</u> <u>Alice</u> <u>Rexroad</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>12-23,</u> <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 15, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo. Moyer</u>				14. MOTHER'S MAIDEN NAME <u>Mary F. Rexroad</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mary F. Doman I05 5th St. City</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4222</u> IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				<u>ten years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) _____							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12-23-55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 21, 1955</u> to <u>Dec. 23, 1955</u> that I last saw the deceased alive on <u>Dec. 23, 1955</u> , and that death occurred at <u>12:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>E. J. Broadbent</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>		DATE SIGNED <u>12-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cem.</u>		LOCATION (City, town, or county) (State) <u>Fort Ashby W. Va.</u>	
24. REC'D BY REGISTRAR <u>Dec. 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>			

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# DEATH CERTIFICATE OF DEATH

Reg. Own No.

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Immediate cause of death

9. Underlying cause of death

10. Contributing cause of death

11. Manner of death

12. Medical certification

13. Signature of physician

14. Signature of registrar

15. Signature of informant

16. Signature of funeral director

17. Signature of health officer

18. Signature of coroner

19. Signature of justice of the peace

20. Signature of other official

21. Signature of other official

22. Signature of other official

23. Signature of other official

BUREAU V. 3

DEC 28 1955

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland. It is the duty of the physician or other qualified person to fill out this certificate accurately and truthfully. It is the duty of the registrar to receive this certificate and to enter it in the death register. It is the duty of the health officer to review this certificate and to sign it if it is correct. It is the duty of the coroner to sign this certificate if the death is suspicious or if the cause of death is unknown. It is the duty of the justice of the peace to sign this certificate if the death is natural and the cause of death is known. It is the duty of the other official to sign this certificate if the death is natural and the cause of death is known.

## 11438 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN CumberlandLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSMemorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE West Virginia COUNTY GrantCITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN PetersburgSTREET  
ADDRESS

(If rural give location)

3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

BABYGIRLRIGGLEMAN4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

DECEMBER 22, 19 55

## 5. SEX

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

## 8. DATE OF BIRTH

## 9. AGE last birthday

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

FemaleWhiteSingleDec. 22, 1955

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)None10b. KIND OF BUSINESS  
OR INDUSTRYCumberland, Maryland12. CITIZEN OF WHAT  
COUNTRY?USA

## 13. FATHER'S NAME

Jesse Riggleman

## 14. MOTHER'S MAIDEN NAME

Mary Lynn Bane15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)No

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT &amp; ADDRESS

Memorial Hospital

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH750x IMMEDIATE CAUSE (A)Anencephaly

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST, DUE TO

(C)

1 hr. 6 min.II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

## 21e. INJURY OCCURRED

While ☐ Not while ☐  
at work el work

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 22, 1955, to Dec. 22, 1955, that I last saw the deceased  
alive on Dec. 22, 1955, and that death occurred at 10:35 AM, from the causes and on the date stated above.

## SIGNATURE

Leland HansonM.D. 63 Greene St., Cumb. Md.

## ADDRESS (Street, city, town, state)

## DATE SIGNED

Dec. 24, 195523. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

BurialDec. 24, 1955Maple Hill CemeteryPetersburg, West Virginia.

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

Dec. 24, 1955 Walter R. Frantz, M.D.J. Blaine Schaeffer, Petersburg, W. Va.20V5322404

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



# CERTIFICATE OF DEATH

Reg. Gen. No.

1. Name of deceased (Print or write)

2. Date of death (Print or write)

3. Place of death (Print or write)

4. Cause of death (Print or write)

5. Manner of death (Print or write)

6. Age at death (Print or write)

7. Sex (Print or write)

8. Race (Print or write)

9. Marital status (Print or write)

10. Occupation (Print or write)

11. Education (Print or write)

12. Date of birth (Print or write)

13. Date of death (Print or write)

14. Date of death (Print or write)

15. Date of death (Print or write)

16. Date of death (Print or write)

17. Date of death (Print or write)

18. Date of death (Print or write)

19. Date of death (Print or write)

20. Date of death (Print or write)

21. Date of death (Print or write)

22. Date of death (Print or write)

23. Date of death (Print or write)

24. Date of death (Print or write)

25. Date of death (Print or write)

26. Date of death (Print or write)

27. Date of death (Print or write)

28. Date of death (Print or write)

29. Date of death (Print or write)

30. Date of death (Print or write)

1. Name of deceased (Print or write)

2. Date of death (Print or write)

3. Place of death (Print or write)

4. Cause of death (Print or write)

5. Manner of death (Print or write)

6. Age at death (Print or write)

7. Sex (Print or write)

8. Race (Print or write)

9. Marital status (Print or write)

10. Occupation (Print or write)

11. Education (Print or write)

12. Date of birth (Print or write)

13. Date of death (Print or write)

14. Date of death (Print or write)

15. Date of death (Print or write)

16. Date of death (Print or write)

17. Date of death (Print or write)

18. Date of death (Print or write)

19. Date of death (Print or write)

20. Date of death (Print or write)

21. Date of death (Print or write)

22. Date of death (Print or write)

23. Date of death (Print or write)

24. Date of death (Print or write)

25. Date of death (Print or write)

26. Date of death (Print or write)

27. Date of death (Print or write)

28. Date of death (Print or write)

29. Date of death (Print or write)

30. Date of death (Print or write)

NOTIFICATION

1. Name of deceased (Print or write)

2. Date of death (Print or write)

3. Place of death (Print or write)

4. Cause of death (Print or write)

5. Manner of death (Print or write)

6. Age at death (Print or write)

7. Sex (Print or write)

8. Race (Print or write)

9. Marital status (Print or write)

10. Occupation (Print or write)

11. Education (Print or write)

12. Date of birth (Print or write)

13. Date of death (Print or write)

14. Date of death (Print or write)

15. Date of death (Print or write)

16. Date of death (Print or write)

17. Date of death (Print or write)

18. Date of death (Print or write)

19. Date of death (Print or write)

20. Date of death (Print or write)

21. Date of death (Print or write)

22. Date of death (Print or write)

23. Date of death (Print or write)

24. Date of death (Print or write)

25. Date of death (Print or write)

26. Date of death (Print or write)

27. Date of death (Print or write)

28. Date of death (Print or write)

29. Date of death (Print or write)

30. Date of death (Print or write)

BUREAU V. 3.

DEC 28 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) 02 TOWN Cumberland LENGTH OF STAY (in this place) 3 daysHOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY AlleganyCITY (If outside corporate limits write RURAL and give nearest town) OR TOWN MidlandSTREET ADDRESS (If rural, give location) /

## 3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)

SusanColleenRobertson

## 4. DATE OF DEATH (Month) (Day) (Year)

Dec.11955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

femalewhitesingleFeb. 24-19487yrs.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

StudentMd.U.S.A.

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

Joseph G. RobertsonErma Lloyd

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

4nononeMemorial Hospital records

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

## INTERVAL BETWEEN ONSET AND DEATH

296X  
Immediate cause(a) Henoch's Purpura

## DUE-TO

## Antecedent cause(s)

(b) Petecheal hemorrhage (generalized)Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

## DUE-TO

(c) Edema of brain & lungs (marked)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

Nov. 29-1955Exploratory laparotomy-negative.

## 20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

## 21c. (City or town)

## (County)

## (State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

## SIGNATURE

H. V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAM.

## DATE SIGNED

Dec. 2-1955

## 23. BURIAL, CREMATION, REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## FUNERAL DIRECTOR

## ADDRESS

Dec. 3, 1955Winter R. Haney, M.D.George Eckhorn, Lonaconing, Md.Eastham

MARGIN RESERVED FOR BINDING

BUREAU V. S.

DEC 6 1955

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town)  
 TOWN Cumberland LENGTH OF STAY (in this place) 5 months

HOSPITAL OR INSTITUTION OR STREET ADDRESS 113 East First St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 OR TOWN Cumberland

STREET ADDRESS (If rural, give location)  
113 East First St.

3. NAME OF DECEASED: (First) (Middle) (Last)  
 (Type or Print) Melvin Kinwood Ruckman

4. DATE OF DEATH (Month) (Day) (Year)  
Dec. 20 1955

5. SEX: male 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married 8. DATE OF BIRTH: April 20-1892 9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Truck Tire Inspector Kelley-S-Tire Co. 10b. KIND OF BUSINESS OR INDUSTRY: Kirby, W. Va. 11. BIRTHPLACE (State or foreign country): U.S.A. 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

William Ruckman

## 14. MOTHER'S MAIDEN NAME:

Mallica Swisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes W.W.I

16. SOCIAL SECURITY No.: 214-07-0641

## 17. INFORMANT &amp; ADDRESS:

(wife) Felicia Morris Ruckman, City.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
 Immediate cause (a) Coronary occlusion

DUE TO

Antecedent cause(s) (b) Coronary sclerosis.

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH  
sudden

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
 DEPUTY MEDICAL EXAMINER ☐  
 ASSISTANT MEDICAL EXAM. ☐

Dec. 20-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE REC'D BY LOCAL REG.

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial Dec. 22, 1955 St. John Cemetery Augusta, West Virginia  
Dec. 21, 1955 Walter R. Frank, M.D. James T. Scarpelli Cumberland, Md.

MARGIN RESERVED FOR BINDING

DEC 27 1955

RECEIVED

BUREAU V. 2



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11441

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11462

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>9 months</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rural) Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Memorial Hospital.</u>				STREET ADDRESS (If rural, give location) <u>R.F.D./#1 Braddock Farms</u>			
3. NAME OF DECEASED: (Type or Print) <u>Mary</u>		(First) (Middle) (Last) <u>Scheurling</u>		4. DATE OF DEATH <u>Dec. 4</u>		(Month) (Day) (Year) <u>19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH: <u>May 12-1905</u>	9. AGE last birthday: <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Mt Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Francis P. Reynolds</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Porter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>4 no</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>R.F.D.#1 Braddock Farm (husband) Lloyd E. Scheurling,</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>331X</u> Immediate cause (a) <u>Cerebral hemorrhage (Apoplexy)</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____						<u>about</u> <u>1/2 hr.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec. 5-1955</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Harty, M.D.</u>		24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>		ADDRESS	

E. Scarpelli

BUREAU V. B.

DEC 9 1955

RECEIVED

## 11442 CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>60 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>314 Baltimore Ave</u>				STREET ADDRESS (If rural give location) <u>314 Baltimore Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Paul Jacob Schultz</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec 24 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>July 24, 1895</u>	
9. AGE last birthday <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>yard Master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Frederick Schultz</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Kolterman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>705-05-8054</u>		17. INFORMANT & ADDRESS <u>Mrs Paul J Schultz - Cumberland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
154X IMMEDIATE CAUSE (A) <u>Carcinoma of rectum &amp; sigmoid</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>			
ANTECEDENT CAUSE(S) DUE TO <u>metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>2603</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Rubeola Mellitus</u>							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> el work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> , to <u>Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>St. Ann's Hospital</u>		ADDRESS (Street, city, town, state) <u>M.D. 1334a Ave, Cumberland, Md</u>		DATE SIGNED <u>12/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marys Catholic Cem</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
24. REC'D BY REGISTRAR <u>Dec. 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Hafer</u>		ADDRESS <u>Cumberland Md.</u>	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

DEC 28 1955

BUREAU V. S.

1544

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11443

## CERTIFICATE OF DEATH

11464

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>02 Cumberland, Md.</u>		LENGTH OF STAY (in this place) <u>7 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 118 Seymour Street</u>				STREET ADDRESS (If rural give location) <u>118 Seymour St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Alvin</u> (Middle) <u>Lee</u> (Last) <u>Sensabaugh</u>				(Month) <u>12</u> (Day) <u>14</u> (Year) <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>May 6, 1955</u>	9. AGE last birthday yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>7</u> Days	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. Sensabaugh</u>				14. MOTHER'S MAIDEN NAME <u>Hazel Jean Sensabaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>John A. Sensabaugh, Cumberland, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
501X IMMEDIATE CAUSE (A) <u>Pulmonary Congestion - Acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Minute.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Laryngeal Infection Bronchitis</u>				<u>24 hrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 14</u> , 19 <u>55</u> , to <u>Dec 15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>55</u> , and that death occurred at <u>1207 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James H. Scarpelli</u>				ADDRESS (Street, city, town, state) <u>M.D. 1330a Ave, Cumberland, Md</u>		DATE SIGNED <u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Pk.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. EC'D BY REGISTRAR <u>Dec. 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Brant, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Scarpelli</u>		ADDRESS	



# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

## 1955 CERTIFICATE OF DEATH

Part One

1. THE DECEASED'S HOME OR RESIDENCE

2. THE DECEASED'S PLACE OF BIRTH

3. THE DECEASED'S PLACE OF DEATH

4. THE DECEASED'S PLACE OF DEATH

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45. THE DECEASED'S PLACE OF DEATH

BUREAU V. S.

DEC 19 1955

RECEIVED

PHOTOCOPY

11470

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural-Cumberland</u>		<u>25 yrs.</u>		TOWN <u>Rural-Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 4, Mexico Farms, Cumberland, Md.</u>				STREET ADDRESS (If rural give location) <u>Rt. 4, Mexico Farms, Cumberland, Md.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Mary</u> (Middle) <u>Frances</u> (Last) <u>Shank</u>				(Month) <u>Dec.</u> (Day) <u>15</u> (Year) <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 4, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>La Vale, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Francis M. DeVore</u>				14. MOTHER'S MAIDEN NAME <u>Rachel E. Everstine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>James W. Shank, Rt. 4, Cumberland</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
463X IMMEDIATE CAUSE (A) <u>Pulmonary Embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Thrombotic phlebitis</u>				<u>weeks?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/> A. <input type="checkbox"/> N. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 16, 1955</u> to <u>Dec. 13, 1955</u> , that I last saw the deceased alive on <u>Nov. 16, 1955</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. A. Hodges</u>		M.D. <u>Cumberland, Md.</u>		ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>		DATE SIGNED <u>12/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12/18/55</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>Dec. 17, 1955</u>	REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Md.</u>			

# CERTIFICATE OF DEATH

Reg. Div. No.

1. DECEASED PERSON'S NAME (as Decedent)

DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH

DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

BUREAU V. S.

EC 21 1955

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT BY THE REGISTRAR OF DEATHS, STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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## CERTIFICATE OF DEATH

Items 8,9,14 FilmG191 1-11-56 et

Reg. Dist. No. 6

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Allegany</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Allegany</i>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Moscow</i>		<i>28 yrs</i>		OR TOWN <i>Moscow</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>MARY LAUDER SHAW</i>				<i>Dec 30 19 55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>July 7, 1876</i>	<i>79</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Domestic</i>		<i>Own home</i>		<i>Riddlesburg, Pa.</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William Lauder</i>				<i>Mary Aschem Lauder</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>				<i>Andrew Shaw, Moscow, Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
420.1 IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>						<i>1 Day</i>	
ANTECEDENT CAUSE(S) DUE TO <i>Arteriosclerosis</i>						<i>10 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Carcinoma of sigmoid</i>						<i>4 yrs</i>	
STATING UNDERLYING CAUSE LAST. (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 12-30, 19 55</i> , to <i>Dec 30, 19 55</i> , that I last saw the deceased alive on <i>12-30, 19 55</i> , and that death occurred at <i>7:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Robert W. Boese</i>				ADDRESS (Street, city, town, state) <i>Piedmont, W.Va.</i>			
M.D.				DATE SIGNED <i>12-31-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1-2-56</i>		<i>Laurel Hill Cem</i>		<i>Moscow, Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>12-31-55</i>		<i>Mrs Jean C. Kelly</i>		<i>E. J. Boral</i>		<i>Westernport, Md.</i>	

# CERTIFICATE OF DEATH

Reg. No. 12

1. Usual Residence (House or Apartment)

2. Date of Death

3. Time of Death

4. Place of Death

5. Cause of Death

6. Manner of Death

7. Age at Death

8. Sex

9. Race

10. Marital Status

11. Occupation

12. Education

13. Date of Birth

14. Date of Admission

15. Date of Discharge

16. Date of Death

17. Date of Death

18. Date of Death

19. Date of Death

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52. Date of Death

53. Date of Death

54. Date of Death

BUREAU V. S.

JAN 2 1966

RECEIVED

NOTIFICATION

1. Name of Person (Last, First, Middle Initial)  
2. Address (Street, City, State, Zip)  
3. Date of Notification  
4. Signature of Person  
5. Signature of Official  
6. Date of Signature  
7. Name of Official  
8. Title of Official  
9. Department of Health  
10. Baltimore, Maryland



Outside of  
City Limits

11472

11467

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TO	
<u>Town Cumberland, rural</u>		<u>00</u>		<u>Near Cumberland, rural</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route #4 - Box 91</u>				STREET ADDRESS (If rural, give location) <u>Route #4 - Box 91</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Chester Edward Sisler</u>				<u>Dec. 11 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>Single</u>	<u>Oct-14-1955</u>	<u>0</u> yrs.	<u>1</u> Months	<u>1</u> Days	<u>19</u> Hours <u>55</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>				<u>Cumberland, Md.</u>		<u>U.S.A</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Darius F. Sisler</u>				<u>Mary Cochran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>none</u>		<u>(father) Darius Sisler, Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>921.0</u>		
Immediate cause	(a) <u>Asphyxia</u>	<u>sudden</u>
DUE TO		
Antecedent cause(s)	(b) <u>Aspiration of stomach contents into bronchi.</u>	
Diseases or conditions, if any, giving rise to the above cause		
DUE TO		
stating underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>home</u>	21c. (City or town) (County) (State)	
		<u>Cumberland Allegany</u>	<u>01</u> <u>Md.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>about 8:30</u> <u>De. 11/55 A. M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Aspiration of stomach contents in bronchi.</u>	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Dec. 11 - 1955

DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec. 13, 1955</u>	<u>St. Basil's Memorial Cme.</u>	<u>Near Cumberland, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Dec. 12, 1955</u>	<u>Walter R. Harty, M.D.</u>	<u>John J. Saffer</u>	<u>"</u>

2005273364

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 14 1955

BUREAU V. 3

1. When corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11444

# CERTIFICATE OF DEATH

11468

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland,</u>				TOWN <u>Cumberland,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>36 Greene St.,</u>				STREET ADDRESS (If rural give location) <u>36 Greene St.,</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES (First) (Middle) (Last) FREDERICK WILLIAM SNYDER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 10, 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 19, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>		11. BIRTHPLACE (State or foreign country) <u>Accident, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Adam Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>4 No,</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Cumberland, Md. Mrs. Planche Snyder 36 Greene St.,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
260X IMMEDIATE CAUSE (A) <u>Diabetes mellitus, diabetic</u>				Antecedent Cause(s) DUE TO (B) <u>Diabetes, Cardio-renal-vascular disease</u>		<u>Sudden</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>disease</u>						<u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 20, 19 50</u> , to <u>Dec 10, 19 55</u> , that I last saw the deceased alive on <u>Dec 10, 19 55</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph R. Crenshaw</u>		DATE THEREOF <u>12/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cem</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Winter R. Trout, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

# CERTIFICATE OF DEATH

FILE NO. 100

1. DEATH CERTIFICATE (NUMBER OF DEATHS)

2. PLACE OF DEATH

3. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 4. PLACE OF DEATH  
 5. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 6. PLACE OF DEATH  
 7. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 8. PLACE OF DEATH

9. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 10. PLACE OF DEATH  
 11. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 12. PLACE OF DEATH

13. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 14. PLACE OF DEATH  
 15. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 16. PLACE OF DEATH

17. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 18. PLACE OF DEATH  
 19. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 20. PLACE OF DEATH

21. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 22. PLACE OF DEATH  
 23. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 24. PLACE OF DEATH

25. DEATH CERTIFICATE (NUMBER OF DEATHS)  
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37. DEATH CERTIFICATE (NUMBER OF DEATHS)  
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 40. PLACE OF DEATH

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49. DEATH CERTIFICATE (NUMBER OF DEATHS)  
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53. DEATH CERTIFICATE (NUMBER OF DEATHS)  
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 56. PLACE OF DEATH

57. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 58. PLACE OF DEATH  
 59. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 60. PLACE OF DEATH

61. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 62. PLACE OF DEATH  
 63. DEATH CERTIFICATE (NUMBER OF DEATHS)  
 64. PLACE OF DEATH

BUREAU V. S.

DEC 19 1955

RECEIVED

SMOOTHING

11445

## CERTIFICATE OF DEATH

11469

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)

TOWN Cumberland,

LENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

110 So. Johnson St.,

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL end give nearest town)

TOWN Cumberland,

STREET  
ADDRESS

110 So. Johnson St.,

3. NAME OF  
DECEASED  
(Type or Print)

(First)

ADDA

(Middle)

ELIZABETH

(Last)

SOWERS

4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

DECEMBER 23, 19 55

## 5. SEX

Female

6. COLOR OR  
RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Married

## 8. DATE OF BIRTH

Oct. 27, 1891

## 9. AGE last birthday

64

yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Housewife

10b. KIND OF BUSINESS  
OR INDUSTRY

Own home

## 11. BIRTHPLACE (State or foreign country)

Hampshire Co. W. Va.

12. CITIZEN OF WHAT  
COUNTRY?

U. S.

## 13. FATHER'S NAME

Samuel H. Largent

## 14. MOTHER'S MAIDEN NAME

Susanna Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

No.

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT &amp; ADDRESS

Cumberland, Md.  
Miss Betty Sowers 110 S. Johnson St.,

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

## IMMEDIATE CAUSE (A)

(A)

Coronary Thrombosis

## ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

Broncho-Pneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

1 1/2 hours

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(If either, notify medical examiner)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While ☐ Not while  
at work ☐ et work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 1955, to Dec 23, 1955, that I last saw the deceased  
alive on Dec 22, 1955, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

## SIGNATURE

B. M. Schindler

M.D.

41 Green St. Cumberland, Md. 12/23/55

## ADDRESS (Street, city, town, state)

## DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

12/26/55

## NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

## LOCATION (City, town, or county)

Cumberland, Maryland

## (State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

Dec. 26, 1955 Walter R. Frantz, M.D.

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

H. Wayne George Cumberland, Md.

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



RECEIVED

Within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11446

# CERTIFICATE OF DEATH

11470

DR. R.J. WILLIAMS

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>24 DAYS</u>		CITY OR TOWN <u>CUMBERLAND</u>		CITY OR TOWN <u>CUMBERLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>33 VIRGINIA AVENUE</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>ANDREW W. SPEARMAN</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>DECEMBER 14 19 55</u>			
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>SINGLE</u>	<b>8. DATE OF BIRTH</b> <u>NOVEMBER 6, 1905</u>	<b>9. AGE last birthday</b> <u>50</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B. &amp; O.R.R.CO.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>ANDREW P. SPEARMAN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ROSE NASH</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>705-05-4368</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>MEMORIAL HOSPITAL - CUMBERLAND, MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE</b> (A) <u>525x Coronary Thrombosis</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Immediate</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Cor Pulmonale</u>						<u>1 mo</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <u>Pulmonary Fibrosis</u>						<u>-</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>-</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.) <u>-</u>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <u>-</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <u>-</u>		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21i. HOW DID INJURY OCCUR?</b> <u>-</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>11/19/55</u> , 19 <u>55</u> , to <u>12/14/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/14/55</u> , 19 <u>55</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>R. J. Williams</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Cumberland</u>		<b>DATE SIGNED</b> <u>12/15/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12-19-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St Perer &amp; Paul Cem.</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Cumberland, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Dec. 19, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Winter R. Frantz, M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>James F. Scarpelli</u> <u>Cumberland, Md.</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

11330

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BUREAU V. S.

DEC 21 1955

RECEIVED

AMOUNT OF TIME

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11471

## 11473 - CERTIFICATE OF DEATH

Reg. Dist. No. 8

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lonaconing</u>		<u>71 yrs.</u>		TOWN <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>East Main Street</u>				<u>East Main Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
<u>CATHERINE STEVENSON</u>				<u>Dec, 20th 55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Single</u>		<u>March 4th. 1884</u>	
						9. AGE last birthday	
						<u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Retired Manager of Cafeteria (School)</u>				<u>Nikep, MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.A.</u>							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Stevenson</u>				<u>Elizabeth Mackey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>						<u>Mrs. Daniel Stakem, Sister</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>10 min</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>arteriosclerosis - coronary</u>		<u>2 year</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Diabetes Mellitus.</u>		<u>5 yrs.</u>	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>August, 1953</u>, to <u>20 Dec, 1955</u>, that I last saw the deceased alive on <u>20 Dec, 1955</u>, and that death occurred at <u>8:20</u> M. from the causes and on the date stated above.</b>							
SIGNATURE <u>George Richard</u>				DATE SIGNED <u>12-22-55</u>			
ADDRESS (Street, city, town, state) <u>Lonaconing, Md</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec, 23, 1955</u>		<u>Oak Hill Cemetery</u>		<u>Lonaconing, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE <u>12-23-55</u>		<u>Jannette M Pool</u>		<u>GEORGE EICHORN, Lonaconing, MD</u>			

# CERTIFICATE OF DEATH

Registration No.

1. MEDICAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH
AGE	SEX	CAUSE OF DEATH	DATE OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF DEATH
AGE	SEX	CAUSE OF DEATH	DATE OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF DEATH
AGE	SEX	CAUSE OF DEATH	DATE OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF DEATH
AGE	SEX	CAUSE OF DEATH	DATE OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF DEATH
AGE	SEX	CAUSE OF DEATH	DATE OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF DEATH
AGE	SEX	CAUSE OF DEATH	DATE OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF DEATH
AGE	SEX	CAUSE OF DEATH	DATE OF DEATH

BUREAU V. S.

DEC 29 1965

RECEIVED

ENCLOSURE



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11458 CERTIFICATE OF DEATH

11472

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg,</u>		<u>15 yrs.</u>		TOWN <u>Frostburg,</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		<u>1</u>	
<u>00</u> <u>236 E. Main Street</u>				<u>236 E. Main Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Elsie May Stewart</u>				<u>Dec. 3rd, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>March 21st, 1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housework</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Owen Lewis</u>				<u>Elizabeth Porter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>None</u>		<u>None</u>		<u>Allen Stewart, Frostburg, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
1. IMMEDIATE CAUSE (A) <u>Generalized Scleroderma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>	
2. ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>3 YRS.</u>	
<u>CHRONIC GLOMERULONEPHRITIS</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>12/3</u>		<u>✓</u>		<u>✓</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>✓</u>		<u>✓</u>		<u>✓</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>✓</u>		<u>✓</u>		<u>✓</u>			
<b>22. I hereby certify that I attended the deceased from <u>SEPT</u>, 19<u>51</u>, to <u>12/3</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/3</u>, 19<u>55</u>, and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.</b>							
SIGNATURE <u>Martin Wooten, M.D.</u>				ADDRESS (Street, city, town, state) <u>48 Broadway - Frostburg, Md.</u>		DATE SIGNED <u>12/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-5-1955</u>		<u>Eckhart Cemetery</u>		<u>Eckhart, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-5-55</u>		<u>Mr. Harvey A. Roe</u>		<u>Joseph R. Durst, Frostburg, Md.</u>			

BUREAU V. S.

DEC 7 1935

RECEIVED

**INSTRUCTIONS**  
1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11447

# CERTIFICATE OF DEATH

11473

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>CUMBERLAND</b>		LENGTH OF STAY (in this place) <b>11 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>				STREET ADDRESS (If rural give location) <b>120 JOHNSON ST.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>MRS ODA B. SULLIVAN</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>DEC. 2. 19 55</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>WIDOWED</b>		<b>8. DATE OF BIRTH</b> <b>SEPT. 15, 1888</b>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>9. AGE last birthday</b> <b>67</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>11. BIRTHPLACE (State or foreign country)</b> <b>WEST VIRGINIA</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>LEONARD VANNOY</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>CATHERINE POLING</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Memorial Hospital</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>153X IMMEDIATE CAUSE (A)</b> <b>Cerebral and bone metastasis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 months</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Carcinoma, Large Bowel</b>				<b>12 months</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Cardiac failure</b>							
<b>19a. DATE OF OPERATION</b> <b>1-3-26-55</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Carcinoma, splenic flexure</b>			
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 3-12, 19 55, to Dec 2, 19 55, that I last saw the deceased alive on Dec 2, 19 55, and that death occurred at 10:18 AM from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Charles Brunstad</i>				<b>DATE SIGNED</b> <i>Dec 3 1955</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Dec 4, 1955</b>			
<b>DATE THEREOF</b> <b>Dec 5, 1955</b>				<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Peter Cemetery</b>			
<b>LOCATION (City, town, or county) (State)</b> <b>Westernport, Alleg. Md.</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Harold Fredlock, Jr.</b>			

CERTIFICATE OF DEATH

REG. DIST. NO.

1. PREVIOUS RESIDENCE (OR HOME) OF DECEASED

WEST MARYLAND COUNTY, MARYLAND

WEST MARYLAND

ALLEGANY

11 DAYS

COLUMBIA

1200 E. 11th St.  
COLUMBIA, MD.

1200 E. 11th St.  
COLUMBIA, MD.

DEC. 5, 1935

SULLIVAN

MA

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

BUREAU V. S.

DEC 6 1935

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits.

11448

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11474

Reg. Dist.

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Cumberland</u>		<u>28 yrs.</u>		TOWN <u>Cresantown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Sacred Heart Hospital.</u>				STREET ADDRESS (If rural, give location) <u>Route #5</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Beatrice S. Thompson</u>				<u>Dec. 24 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>white</u>	<u>married</u>	<u>Dec. 1-1903</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Davis, W. Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Nola G. Shobe</u>				<u>Ida May Koontz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>4 no</u>		<u>none</u>		<u>W. Va. (sister) Mrs. Ed. Fraley, Rt. 1, Ridgely</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Myocardial failure</u>						<u>sudden</u>	
DUE TO						<u>about 3</u>	
Antecedent cause(s) (b) <u>Myocarditis with coronary sclerosis</u>						<u>years</u>	
Diseases or conditions, if any, giving rise to the above cause DUE TO						<u>about</u>	
stating underlying cause last (c) <u>also had diabetes mellitus</u>						<u>10 years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>0</u>				<u>0</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>M.</u>		<u>at work</u>		<u>0</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
<u>H.V. Deming M.D.</u>				<u>Dec. 24-1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):				LOCATION (City, town, or county) (State)			
<u>Burial</u>				<u>Crest Burial Park, Cumberland, Md</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec. 26, 1955</u>		<u>Walter R. Krantz, M.D.</u>		<u>John J. Hafer, Cumberland, Md</u>		<u>Hafer</u>	



BUREAU V. S.

DEC 28 1955

RECEIVED

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11474 **CERTIFICATE OF DEATH**

11475

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) <u>Mt. Savage</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Lifetime</u>		STREET ADDRESS (If rural give location)		/	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Jesse Earl Trimble</u>				<u>Dec. 22nd, 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 8th, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired miner</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Coal Mining</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>George T. Trimble</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Helen A. Trimble</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> (Rural) <u>Mrs. Susanna Trimble, Mt. Savage, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>4343</b> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Heart Disease</u>				<u>Years -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Dec 1, 19 55</u>, to <u>Dec 22, 19 55</u>, that I last saw the deceased alive on <u>Dec 21, 19 55</u>, and that death occurred at <u>11:00AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>John B. Davis, M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Frostburg, Md.</u>		<b>DATE SIGNED</b> <u>12/22/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12-24-1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Georges Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Mt. Savage, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Nancy N. Ritz</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Durst</u>		<b>ADDRESS</b> <u>Frostburg, Md.</u>	
<b>DATE</b> <u>12-23-55</u>							

# CERTIFICATE OF DEATH

Reg. Dist. No.

TO HAVE ASSIGNED NAME OF DECEASED

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF RECOVERY

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF RECOVERY

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF RECOVERY

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF RECOVERY

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

AMOUNT OF DEATH

BUREAU V. S.

DEC 27 1955

RECEIVED

18-33-27

11476

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11449

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>CUMBERLAND</b>		<b>31 DAYS</b>		TOWN <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>109 PARK STREET</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>SARAH MILDRED TWIGG</b>				<b>12/29/1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)		
<b>FEMALE</b>	<b>WHITE</b>	<b>DIVORCED</b>	<b>FEBRUARY 15, 1877</b>	<b>78</b> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>Housewife</i>		<i>Own home</i>		<b>WEST VIRGINIA</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>WILLIAM J. PENNINGTON</b>				<b>BETSY JONES</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No</b>		<b>None</b>		<b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>1999 IMMEDIATE CAUSE (A)</b>				<b>PERITONEAL CARCINOMATOSIS</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<b>Primary site unknown</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>SEPT. 28, 1955</b>		<b>metastatic Ca - generalized abdomen</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 9-19, 1955, to 12/29, 1955, that I last saw the deceased alive on 12/29, 1955, and that death occurred at 7:35AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>DATE SIGNED</b> <b>Cumberland Md. 12/30/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>				<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<b>Burial</b>				<b>12/31/55</b>		<b>Hillcrest Cemetery</b>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<b>Dec. 31, 1955</b>				<b>Walter R. Bantz, M.D.</b>		<b>Louis Stein, Inc. Cumberland, Md.</b>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

1955-001-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. DATE OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. DATE OF DEATH

12. TIME OF DEATH

13. PLACE OF DEATH

14. SEX

15. RACE

16. OCCUPATION

17. DATE OF BIRTH

18. PLACE OF BIRTH

19. DATE OF DEATH

20. TIME OF DEATH

21. PLACE OF DEATH

22. CAUSE OF DEATH

23. DATE OF DEATH

24. TIME OF DEATH

25. PLACE OF DEATH

26. SEX

27. RACE

28. OCCUPATION

29. DATE OF BIRTH

30. PLACE OF BIRTH

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF DEATH

34. SEX

35. RACE

36. OCCUPATION

37. DATE OF BIRTH

38. PLACE OF BIRTH

39. DATE OF DEATH

40. TIME OF DEATH

41. PLACE OF DEATH

42. SEX

43. RACE

44. OCCUPATION

45. DATE OF BIRTH

46. PLACE OF BIRTH

BUREAU V. S.

JAN 4 1956

RECEIVED

MASSACHUSETTS

DEPARTMENT OF HEALTH - BOSTON  
This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of Vital Records, State House, Boston, Massachusetts.



11450

## CERTIFICATE OF DEATH

DR. HODGES

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY (in this place) 11 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND, RURAL		STREET ADDRESS (If rural give location) RT. #3, BEDFORD ROAD	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) EDGAR (Middle) D. (Last) VANDEGRIFT				(Month) DECEMBER (Day) 2, (Year) 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH APRIL 3, 1904	9. AGE last birthday 51 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN VANDEGRIFT				14. MOTHER'S MAIDEN NAME FRANCES MARTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 214-05-6207		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A) Massive intracranial hemorrhage - 2 hrs				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO Metastatic lesion brain ?							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO Carcinoma prostate 3 yrs +							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 3/9/55		19b. MAJOR FINDINGS OF OPERATION Ca of prostate		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/21, 19 55 to 12/2, 19 55, that I last saw the deceased alive on 12/2, 19 55, and that death occurred at 5:40 AM, from the causes and on the date stated above.							
SIGNATURE W. R. Hodges				ADDRESS (Street, city, town, state) Cumberland, Md. DATE SIGNED 12/2/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 12/4/55		NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		LOCATION (City, town, or county) (State) Cumberland Maryland	
24. REC'D BY REGISTRAR Dec. 4, 1955		REGISTRAR'S SIGNATURE Winter R. Gantz M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. ADDRESS Cumberland, Md.			

INSTRUCTIONS

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VS A13C 1-55 10M

# 1470 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME: CUMBERLAND

AGE: 11 DAYS

SEX: MALE

DATE OF BIRTH: DECEMBER 2, 1955

PLACE OF BIRTH: CUMBERLAND, MARYLAND

DATE OF DEATH: DECEMBER 2, 1955

TIME OF DEATH: 11:00 AM

PLACE OF DEATH: CUMBERLAND, MARYLAND

DATE OF DEATH: DECEMBER 2, 1955

TIME OF DEATH: 11:00 AM

PLACE OF DEATH: CUMBERLAND, MARYLAND

DATE OF DEATH: DECEMBER 2, 1955

TIME OF DEATH: 11:00 AM

PLACE OF DEATH: CUMBERLAND, MARYLAND

DATE OF DEATH: DECEMBER 2, 1955

TIME OF DEATH: 11:00 AM

PLACE OF DEATH: CUMBERLAND, MARYLAND

DATE OF DEATH: DECEMBER 2, 1955

TIME OF DEATH: 11:00 AM

PLACE OF DEATH: CUMBERLAND, MARYLAND

DATE OF DEATH: DECEMBER 2, 1955

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PLACE OF DEATH: CUMBERLAND, MARYLAND

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DATE OF DEATH: DECEMBER 2, 1955

TIME OF DEATH: 11:00 AM

PLACE OF DEATH: CUMBERLAND, MARYLAND

DATE OF DEATH: DECEMBER 2, 1955

BUREAU V. 2

DEC 6 1955

RECEIVED

RECEIVED

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INSTRUCTIONS

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VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11478

Within corporate limits **11451** **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>22 Years</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>115 Harrison</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Otis</u> (Middle) <u>H</u> (Last) <u>Wilfong</u>				(Month) <u>12</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8/17/92</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co</u>		11. BIRTHPLACE (State or foreign country) <u>Harman West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Wilfong</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Arbogast</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-6789</u>		17. INFORMANT & ADDRESS <u>Stanley Wilfong Cumberland, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
151X IMMEDIATE CAUSE (A) <u>asphexia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>caner of stomach</u>				<u>3 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>intestinal obstruction</u>							
19a. DATE OF OPERATION <u>11-2-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>colectomy</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>10-31-</u>, 19 <u>55</u>, to <u>12-6-</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>12-5-</u>, 19 <u>55</u>, and that death occurred at <u>11 A</u>.M., from the causes and on the date stated above.</b>							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>576 W. 11th St. Cumberland, Md.</u> DATE SIGNED <u>12-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 8 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. R. J. Ranty, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
DATE <u>Dec 7, 1955</u>							

